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**WOMEN'S EXPERIENCES OF
BREASTFEEDING:
AN INTERPRETIVE
PHENOMENOLOGICAL STUDY**

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for the degree of Doctor of Health Science**

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ABSTRACT

Background:

Breastfeeding is a key public health issue, conferring benefits associated with both infant and maternal health. Despite an increasing research base about what helps or hinders breastfeeding, there is a dramatic drop in breastfeeding prevalence within the first six weeks following birth. The reasons that mothers give for stopping breastfeeding suggest that few mothers gave up because they planned to. This would appear to suggest that there is a gap between women's experiences of breastfeeding and professional practice to promote, support and increase duration.

Methodology:

Using an interpretive phenomenological methodology this study was designed to capture mothers' own interpretations of their experiences of breastfeeding. In-depth interviews with 22 women from the city and surrounding areas of Lincoln were conducted and analysed.

Findings:

Analysis of the data from interviews with 22 primiparous and multiparous mothers resulted in the emergence of three main overarching themes: reality shock, illusions of compliance and tensions. Sub-themes included idealised expectations, incessant demands, onus of responsibility, playing the game, breaking the rules, surveillance and scrutiny, conflicts and contradictions, and cultural constructs.

Conclusions:

The findings from this study revealed that women were ill-prepared for the realities of breastfeeding and for most women the shock of this experience was overwhelming. Those women who struggled to establish breastfeeding did so in silence. They tried to hide their vulnerabilities rather than admit that they were not coping. A lack of peer and family support, combined with the rigid and inflexible approach espoused by health care professionals, led to the perception that exclusive breastfeeding was an unrealistic and unattainable ideal. This has clear implications for practice and policy.

PAPERS ASSOCIATED WITH THIS THESIS

Publications (peer reviewed)

Spencer, R.L.; Greatrex-White, S. and Fraser, D.M. (2010) 'Practice improvement, breastfeeding duration and health visitors.' *Community Practitioner*, 83 (9) 19-22.

Spencer, R.L. (2008) 'Research methodologies to investigate the experience of breastfeeding: a discussion paper.' *International Journal of Nursing Studies*, 45 (12) 1823-1830.

Spencer, R. (2007) 'Ontological perspectives of breastfeeding.' *British Journal of Midwifery*, 15 (12) 779-783.

Presentations at conferences

June 2013 Nutrition and Nurture in Infancy and Childhood:
Bio-Cultural Perspectives, Grange over Sands,
Cumbria:

*'Keeping up Appearances: Women's experiences of
infant feeding'*

October 2010 CPHVA Annual Conference, Harrogate:

*'Health Visitors and the potential impact of
practice improvement strategies to improve
breastfeeding duration.'*

September
2008 7th Annual Qualitative Research Conference,
Bournemouth:

*'Methodologies for Researching Women's
Experiences of Breastfeeding.'*

GLOSSARY OF TERMS USED

Any or partial breastfeeding: some breastfeeding plus water-based fluid, solids, milks or gruels.

Artificial feeding: feeding a baby on a breast milk substitute.

Baby Friendly Hospital Initiative (BFHI): an approach to transforming maternity practices as recommended by the joint UNICEF / WHO statement on the protection, promotion and support of breastfeeding (WHO, 1991). WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) in 1992. The foundations for the BFHI are the 'Ten Steps to Successful Breastfeeding' described in the *Innocenti Declaration on the protection, promotion and support of breastfeeding* (WHO, 1991), and observation of the principles and aim of the International Code of marketing of breast-milk substitutes.

Bottle feeding: feeding an infant from a bottle, whatever is in the bottle, including expressed breast milk, formula, water.

Breast milk substitute: any food being marketed or otherwise represented as a partial or total replacement for breast milk, whether or not it is suitable for that purpose.

Commercial infant formula: a breast milk substitute formulated industrially in accordance with applicable *Codex Alimentarius* standards to satisfy the nutritional requirements of infants during the first months of life up to the introduction of complementary foods.

Complementary feeding: feeding both breastmilk and anything else: any food or liquid including non-human milk and formula.

Dasein: the human mode of existence.

Duration of breastfeeding: the period beyond the first nutritive breastfeed for which a baby continues to feed at the breast.

Exclusive breastfeeding: breastfeeding whilst giving no other food or liquid, not even water, with the exception of drops or syrups consisting of vitamins, mineral supplements or medicines.

Expressed breast milk: milk that has been removed from the breasts, either manually or by using a pump.

Fore-conception: the ideas we bring.

Fore-having: already there, knowing.

Fore-sight: the ability to imagine how it might be.

Hand expression: the expression of milk from the breast by hand.

Hermeneutic: interpretive.

Hermeneutic circle: a continuous process of interpreting experience and reinforcing, enhancing or revising perceptions.

Historicality: a person's history or cultural background.

Lactogenesis II: the onset of copious milk secretion after parturition (childbirth) (Riordan, 2005).

Multigravida: a woman who is or has been pregnant for at least a second time.

Multiparous: a woman who has borne more than one child.

Peer support: support offered by women, usually trained, who have breastfed and are from a similar socio-economic, ethnic or cultural background to the client.

Phenomenology: the science of phenomena, an approach that concentrates on the study of consciousness and the objects of direct experience.

Presence-at-hand: refers to how things are given to us in mere perception, they are viewed as merely theoretical.

Predominant breastfeeding: Breast milk as the predominant source of nourishment, may include certain liquids (water and water-based drinks, fruit juice), oral rehydration therapy, drops or syrups (vitamins, minerals, medicines). It excludes feeding with anything else (in particular, non-human milk, food-based fluids).

Primigravida: a woman who is pregnant for the first time.

Primiparous: a woman who has given birth only once.

Projection: refers to our act of understanding, to reach ahead into the meaning of something in order to understand it.

Ready-to-hand: as 'ready-to-hand', things are given in order to accomplish something else, for example instruments, objects, equipment.

Supplementary feeding: supplementary feeds are feeds given to a baby under six months old to supplement his intake of breast milk.

Throwness: relates to how we are thrown into a world of understanding, in a shared community and culture at a specific historical period.

UNICEF: United Nations Children's Fund.

Un-ready-to-hand: unavailability of something, whether missing, unusable or something that concerns us greatly and requires our attention.

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CHAPTER ONE

INTRODUCTION

1.1 INTRODUCTION

I became interested in breastfeeding at the beginning of my career as a midwife in 1993. As a newly qualified midwife at a hospital in the East Midlands I noticed how much time and effort was made by midwives to help and support women with breastfeeding, both on the postnatal ward and in the community. I also noted the extent to which the act of breastfeeding impacted upon women themselves. Whilst at that point I had no personal experience of breastfeeding, I had been exposed as a teenager to my aunt breastfeeding her babies. It seemed a natural bodily function and at that time I did not question any alternative method of infant feeding. In 1996 I undertook a degree in public health nursing that also led to gaining qualification as a health visitor. The curriculum contained very little educational input regarding infant feeding. We were provided with half a day's theoretical input on breastfeeding that was solely about the physiology of lactation and principles of initiation. As one of only two midwives in the cohort of student health visitors, I was worried about the lack of importance placed upon our public health role, particularly the lack of emphasis on breastfeeding beyond initiation and physiology.

The spark of interest was further ignited with the birth of my first child in 1998. It provided an opportunity to reflect upon the stark differences of my professional experience to my personal experience of breastfeeding. Women largely struggled with physical discomfort and pain from bleeding and cracked nipples, and a lack of awareness or expectation of the physical and emotional effort breastfeeding required, especially in the early postnatal period. This was not reflected in my personal experience which I found to be an enjoyable activity, without encountering any physical difficulties or discomfort. In seeking some illumination of these issues from the literature and through professional and personal contact with mothers, regardless of their method of infant feeding, I became acutely aware of the strong and long lasting feelings associated with breastfeeding. Contact with other mothers and health care professionals (with whom I had not worked professionally) whilst on maternity leave in early 2006 highlighted once again the different discourses evident in relation to breastfeeding and cemented my decision to explore this further.

Having identified how I became interested in breastfeeding, this chapter will provide a rationale and define the research question for the study. The chapter concludes with an outline of the structure of the thesis with a précis of the contents of each chapter.

1.2 RATIONALE

This research study was inspired, in part, by results published in the *Infant Feeding Survey 2005* that nearly three quarters of the women surveyed who stopped breastfeeding in the first six weeks reported that they would have liked to have continued for longer (Bolling et al, 2007). The World Health Organisation and UNICEF (2003) promote exclusive breastfeeding for six months and continued breastfeeding for at least up to the age of two years. At the start of this study, data obtained from the Infant Feeding Survey 2005 stated that across the United Kingdom 65% of mothers were exclusively breastfeeding at birth (Bolling et al, 2007). By 2010, this figure had risen to 69% (Health and Social Care Information Centre [HSCIC], 2012). Breastfeeding rates then drop rapidly over the first six weeks to 21% in 2005 (Bolling et al, 2007) and 23% in 2010 (HSCIC, 2012). Exclusive breastfeeding rates at six months remained unchanged over the same time period, at less than one per cent (HSCIC, 2012). This is in stark contrast to other countries: for example, in New Zealand 68% of women are exclusively breastfeeding at 4-6 weeks (Cattaneo et al, 2005). Qualitative research into mothers' experiences of breastfeeding has discovered that breastfeeding is an '*engrossing, personal journey*' (Nelson, 2006, p15) synonymous with the concept of being a 'good mother' (Carter, 1995; Murphy, 1999, 2000, 2004). Premature cessation has been seen as a personal failure (Lawson and Tulloch, 1995) accompanied by intense and sustained feelings of grief (Battersby, 2000; Mozingo et al, 2000; Ryan and Grace, 2001; Shakespeare et al, 2004). Hence breastfeeding appears to be an intense and profoundly human experience and not simply a physical act of transference of nutrition from mother to infant.

Those mothers who choose to initiate breastfeeding at birth may face difficulties in continuing breastfeeding. A number of reasons are cited by mothers in the quinquennial surveys of UK infant feeding practices for stopping breastfeeding within the first seven days, including:

- baby would not suck or rejected the breast
- painful breasts
- maternal concerns regarding insufficient milk supply.

It has been suggested that these concerns may be given by women as a substitute for other reasons that they are either unable or unwilling to articulate (Bates, 1996).

There is a rich body of knowledge on the health benefits of breastfeeding, for infant, mother and society (for example Ip et al, 2007). International, national and local policy drives to improve breastfeeding prevalence have been developed in recognition of the poorer health outcomes associated with formula feeding. Widespread implementation of strategies and initiatives such as the Baby Friendly Hospital Initiative (UNICEF, 2008) have been credited with an increase in breastfeeding initiation at birth in the United Kingdom. However, there has been little impact on breastfeeding continuation rates. Of significance, in Lincolnshire, the prevalence of breastfeeding at 6-8 weeks shows a decreasing trend year on year (2008-2012) (East Midlands Public Health Observatory [EMPHO], 2012). The latest national Infant Feeding Survey (HSCIC, 2012) results

and local breastfeeding data (EMPHO, 2012) would appear to suggest that there is a gap between women's experiences of breastfeeding in society and professional practice to promote, support and increase breastfeeding continuation. A research study designed to explore the phenomenon of breastfeeding as experienced by women in the city where I work is therefore justified. Understanding this phenomenon might influence policy-makers, health care professionals and educators, in addition to enabling appropriate strategies for practice improvement and health promotion to be generated.

1.3 RESEARCH QUESTION

I began this study with the aim of exploring women's experiences of breastfeeding. This aim emerged as a result of reflecting on my professional experiences in midwifery and health visiting practice, my personal experience as a breastfeeding mother, and understanding of the literature on breastfeeding. The research study has been organised around one research question:

'How is the phenomenon of breastfeeding manifest in the lives of women in one East Midlands city?'

1.4 THESIS STRUCTURE

This thesis is presented as a series of chapters. Chapter two contextualises the study, presenting some of the biases and assumptions underlying breastfeeding research, including an overview of the breastfeeding literature. Short and long term health benefits of breastfeeding for both infants and mothers in developed countries are identified; incidence and prevalence of breastfeeding; international, national and local targets for infant feeding; support for breastfeeding in the United Kingdom, and factors affecting early cessation are presented. A comprehensive review of empirical research relating to women's experiences of breastfeeding in the United Kingdom is also presented.

Chapter three presents a detailed description of the philosophical approach underpinning this study, outlines the research question and describes the research design. Using an interpretive phenomenological methodology (Heidegger, 1962) this study was designed to capture mothers' own interpretations of their experiences. Details of the setting in which the study was conducted, and research activities are presented.

Chapter four provides a brief introduction to the findings and demographic details of the participants. An overview of all the participants involved is provided as contextual background. Chapters five, six and seven present women's experiences of breastfeeding. The findings are presented in three themes, presented in separate chapters. Each chapter presents the findings, followed by discussion and interpretation of that theme.

Chapter five provides an account of the women feeling ill-prepared for the incessant demands and onus of responsibility of breastfeeding. This led the theme to be titled 'reality shock' as it describes the overwhelming shock the women encountered in this new role.

Chapter six describes and discusses the second theme 'illusions of compliance' which was used to describe how some of the women maintained a public pretence in relation to how they themselves were feeling about breastfeeding. They presented themselves as a coping mother, even though they may not have felt like one. This stemmed from a desire not to be seen as a failure. Maintaining an illusion of compliance, they did not adhere strictly to breastfeeding information provided by health care professionals, which they viewed as rigid and inflexible, but sought a pragmatic approach to infant feeding that met their own needs, and those of their family and friends.

Chapter seven describes 'tensions' and mixed messages regarding breastfeeding. The women felt scrutinised in their ability to breastfeed their own infants, and described conflicting viewpoints of breasts as sexualised and nurturing, relational components of breastfeeding versus a medicalised approach, images of breastfeeding in terms of the age of the infant, and about how breastfeeding is perceived in shared public spaces such as shops, pubs and workplaces, but also in their own homes. The women also described how these perceptions and cultural messages impacted on their own breastfeeding experiences, and how they managed breastfeeding as a result.

Chapter eight, the final chapter of this thesis, presents an overview of the study, conclusions drawn from the key themes identified, and the implications for midwifery practice. This chapter includes a critical discussion of the findings and an elaboration on the empirical and theoretical contribution to the existing literature relating to the phenomenon of breastfeeding. A personal reflection on the research journey and the strengths and limitations of the study are identified. The implications of the study findings for health care professional practice are discussed, and suggestions for further research outlined.

Having provided an overview of the key concepts involved in this thesis, chapter two provides a more detailed appraisal of the background literature.

CHAPTER TWO

BACKGROUND AND LITERATURE REVIEW

2.1 INTRODUCTION

The decision to explore women's experiences of breastfeeding locally arose from concerns that Lincolnshire's breastfeeding initiation and continuation rates were some of the worst in the country. This chapter begins by providing a detailed description of the factors that influenced the direction of the study. These factors include: the health benefits, incidence and prevalence of breastfeeding, policies and initiatives, support and early cessation of breastfeeding.

The second part of the chapter discusses the literature review that was undertaken to assist in the study design as well as the relevant literature that has been published during the course of the study. The summary identifies the key issues that were then taken into account in developing the research design and methods.

2.2 BACKGROUND

Breastfeeding is a key public health issue, conferring benefits associated with both infant and maternal health. There is a plethora of research data demonstrating that human breast milk provides complete nutrition for

human infants (Fairbank et al, 2000). In order to explore why breastfeeding is promoted, the key health benefits for both mothers and infants are highlighted in the following sub section. An outline of the economic importance of breastfeeding in the United Kingdom is also included.

2.2.1 HEALTH BENEFITS AND ECONOMIC IMPORTANCE OF BREASTFEEDING IN DEVELOPED COUNTRIES

The scientific evidence about nutrition and maternal and infant health is predominantly confined to observational studies. This is primarily due to a number of issues in collecting and interpreting scientific data on infant nutrition. Whilst randomised controlled trials might be considered the gold standard in terms of scientific evidence base, it would be both unethical and unfeasible to randomly assign infants to either be fed on proprietary infant formulae, or be breast fed. As such, the evidence base upon which public health recommendations for infant feeding are based is fervently debated (for example Buyken et al, 2008; Fewtrell, 2011). Caution in interpretation is thus advised as there are limitations to the strength of evidence that observational studies can give due to selection bias, confounding factors, differences in definitions of breastfeeding and quantifiable outcomes. However, there is published evidence arising from 1 intervention study. The Promotion of Breast-feeding Intervention Trial (PROBIT) is a cluster-randomised trial involving 31 maternity hospitals in Belarus that were randomised to either breastfeeding promotion on the basis of the WHO/UNICEF Baby Friendly Hospital Initiative or standard care (Kramer et al, 2001). All singleton full-term infants with a birth weight of

at least 2.5 kg born at the included hospitals were enrolled in the PROBIT study. Because all infants in this study were initially breastfed, effects of different duration of total and exclusive breastfeeding, rather than differences between breast and formula feeding, can be explored.

Horta et al (2007) conducted a review to assess the effects of breastfeeding on chronic diseases. Ip et al (2007) also reviewed the evidence on the effects of breastfeeding on short and long term infant and maternal health in developed countries. These are summarised in table 1. The strongest scientific data are for a reduced risk of infection, particularly gastroenteritis and otitis media. Data on other short term health benefits for infants are less robust. Data on later cognitive outcome remain controversial. In adolescence and adulthood, four meta-analyses have reported an association of breastfeeding and a reduction in the risk of obesity compared with those who were not breastfed (Arenz et al, 2004; Harder et al, 2005; Owen et al, 2005; Weng et al, 2012). Childhood obesity is associated with a range of life-threatening and debilitating physical and psychosocial consequences (Weng et al, 2012). In the UK, the prevalence of childhood obesity has increased significantly since 1995 (NHS Information Centre, 2007). Lincolnshire has a higher percentage of children classified as obese or overweight than the England average (National Child Measurement Programme, 2012).

The evidence indicates a dose-response protective effect of breastfeeding for mothers (Ip et al, 2007). Whilst there is moderately strong evidence that women who breastfeed are less likely to develop type 2 diabetes, there was no significant effect in women with a history of gestational

diabetes. Inconsistent and contradictory results have been published from studies into postpartum depression and breastfeeding. Different criteria were used to define depression across the studies, which were conducted on small numbers of subjects. Overall it is thought that postpartum depression leads to early cessation of breastfeeding rather than breastfeeding altering the risk of depression.

	Strongest evidence	Moderate evidence	No significant effect, relation unclear
Infant	Gastroenteritis Otitis media Lower respiratory tract infection Atopic dermatitis Sudden Infant Death Syndrome Childhood leukaemia	Cardiovascular health outcomes – plasma lipid profile, blood pressure, risk of obesity Type 1 diabetes Type 2 diabetes	Cognitive development Childhood asthma
Maternal	Breast cancer Ovarian cancer	Type 2 diabetes Hypertension Cardiovascular disease Hyperlipidaemia	Postpartum depression Osteoporosis Postpartum weight loss

Table 1: Summary of the effects of breastfeeding on short and long term infant and maternal health in developed countries (Horta et al, 2007; Ip et al, 2007)

Health and development outcomes related to not breastfeeding are associated with a substantial cost burden. A recent study reporting potential cost benefits of increasing breastfeeding rates in the UK has been published (Renfrew et al, 2012). The researchers calculated how raising breastfeeding rates would save money through reducing illness. Economic models were produced for four acute conditions in infants: gastrointestinal disease, respiratory disease, otitis media and necrotising enterocolitis. The authors reported that increases in breastfeeding could see potential savings to the NHS of around £17 million per year (calculating the reductions in hospitalisations, GP visits, and treatments for these conditions). These figures were costed assuming rates of 45% of babies being exclusively breastfed for four months and 75% of babies in neonatal units breastfed at discharge (Renfrew et al, 2012).

The potential economic benefits of breastfeeding for mothers were also included in this report (Renfrew et al, 2012). Quantitative modelling using evidence in relation to breast cancer in mothers found that if half those mothers who do not currently breastfeed were to do so for up to eighteen months of their lives, an incremental benefit of over £31 million over the lifetime of each annual cohort (approximately 313,000) of primigravid mothers (Renfrew et al, 2012).

2.2.2 INCIDENCE AND PREVALENCE OF BREASTFEEDING

Data on the incidence and prevalence of breastfeeding is an important component in the development of health care professional practice and public health policies and interventions. This sub section is a compilation of self-reported data from individual experts in different countries. The term breastfeeding may refer to different forms of infant feeding patterns in research studies, which could influence comparison and application of findings (Binns et al, 2009). Methodological issues can also include recall bias and failures to report gestational age of infants (Callen and Pinelli, 2004). The World Health Organisation [WHO] working group (2008) proposed several criteria in order to assess infant feeding within and across countries: 'exclusive breastfeeding', 'predominant breastfeeding', 'bottle feeding' and 'complementary feeding' (glossary, page v of this thesis). The calculation of breastfeeding rates for each category is based on feeding practice within the previous 24 hours and the age of the child.

Globally, breastfeeding initiation and duration has fallen over the past century, reaching an all-time low in the 1960s and 1970s, prior to which breastfeeding largely constituted the sole source of human infant nutrition (Hoddinott et al, 2008). Successive surveys by the Office of National Statistics [ONS] have shown that the incidence and prevalence of breastfeeding in the United Kingdom have increased since 1990. Initial breastfeeding rates in 2010 were 81% for the United Kingdom as a whole (HSCIC, 2012), a rise of 5% from the previous quinquennial survey (Bolling et al, 2007). However, this initial breastfeeding rate includes all babies who were put to the breast, even if this was on one occasion only. It also includes

giving expressed breast milk. Locally, initiation rates of 73% for the East Midlands region and 72% for Lincolnshire have been reported (HSCIC, 2012). Whilst it is acknowledged that there are varying degrees of accuracy, completeness and consistency in data collection across member states of the European Union, Norway reported an initiation rate of 99% in 1998; Lithuania and Denmark 98%, and at 6 months 46% of Austrian women are exclusively breastfeeding (Cattaneo et al, 2005). Rates of initiation of breastfeeding in the United Kingdom, Ireland and France are among the lowest in Europe (EU Project on Promotion of Breastfeeding in Europe, 2008).

There is a noticeable fall-off in breastfeeding during the early postnatal period. The latest quinquennial survey results (HSCIC, 2012) demonstrate that breastfeeding prevalence at 6-8 weeks:

United Kingdom 55%

England 46%

East Midlands 42%

Lincolnshire 39%

The figures indicate a higher fall-off rate between initiation and 6-8 weeks in Lincolnshire (33%) than in England (28%) and the United Kingdom (26%) (HSCIC, 2012). Again, in comparison with other European countries with median rates of breastfeeding of five months or over, the median rate in the United Kingdom is one month (Nicoll et al, 2002).

Prevalence of exclusive breastfeeding (defined as the proportion of all babies who are being exclusively breastfed at specific ages) demonstrated a slightly different perspective. Across the United Kingdom, almost two-thirds of mothers (69%) were exclusively breastfeeding at birth (HSCIC, 2012), indicating that a substantial proportion of mothers gave their baby something other than breast milk on the first day. At one week less than half of all mothers (46%) were exclusively breastfeeding, while this had fallen further to 23% by six weeks (HSCIC, 2012). At six months levels of exclusive breastfeeding were negligible. In Lincolnshire, the lowest rate of six week prevalence is in Lincoln (EMPHO, 2012). It is worth reiterating that whilst the rate of initiation of breastfeeding in the United Kingdom has shown a steady increase from 1990 when 62% of women initiated breastfeeding (Hamlyn et al, 2002), the rates of exclusive breastfeeding in the early weeks and months over the same time period has shown only marginal increases (HSCIC, 2012). Of significance, in Lincolnshire the prevalence of breastfeeding at 6-8 weeks shows a decreasing trend year on year (2008-2012) (EMPHO, 2012).

Accepting scientific and epidemiological evidence that breastfeeding is beneficial for both infant and maternal health, and potential increases in breastfeeding rates would save NHS finances, international initiatives have been instigated over the past thirty years in an effort to increase breastfeeding rates. These are outlined in the next sub section.

2.2.3 POLICIES AND INITIATIVES

A review of evidence has demonstrated that on a population basis, exclusive breastfeeding for the first 6 months of life is the optimal way of feeding infants (WHO, 2002). Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond (WHO and United Nation Children's Fund [UNICEF], 2003). However, breastfeeding initiation rates have reduced markedly around the world over the past 150 years (Coates and Riordan, 2005; Palmer, 2009). Whilst the development of formula milks has been largely credited with this decline (Wolf, 2010), changes in infant care practices, suboptimal breastfeeding support, social change and availability of formula milks have contributed to this (Coates and Riordan, 2005).

WHO and UNICEF constructed a range of strategic initiatives to address issues undermining breastfeeding:

1981 The WHO Code of marketing breast-milk substitutes was launched in response to aggressive marketing of infant formulae. This WHO code was endorsed by 118 countries.

1989 joint WHO/UNICEF statement prepared to increase awareness of the critical role that health services play in promoting breastfeeding. Included a set of best practice standards for

maternity units. '*Ten steps to successful breastfeeding*' (appendix 1) developed.

1991 the *Innocenti Declaration on the protection, promotion and support of breastfeeding* issued by WHO. This document was internationally endorsed and contained a set of social policy targets to be reached by governments to assist a change in culture.

1992 WHO and UNICEF launched the Baby-friendly Hospital Initiative (BFHI) globally in an attempt to support the development of an infrastructure by maternity care facilities to support breastfeeding.

The foundations for the BFHI are the *Ten Steps to Successful Breastfeeding*, the *Innocenti Declaration* and the *International Code of Marketing of Breast-milk Substitutes*.

2003 *Global strategy for infant and young child feeding* (WHO and UNICEF, 2003).

2008 adoption of the EU Blueprint (EU Project on Promotion of Breastfeeding in Europe, 2008).

The BFHI is a multi-faceted intervention and systems approach, combining research evidence and good practice standards that cover all aspects of service provision and care. The BFHI has been implemented in about 15000 hospitals in 171 countries and has been described as contributing to

improving the establishment of exclusive breastfeeding worldwide (UNICEF, 2008). NICE (2006) postnatal care guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS. Hospitals are awarded Baby Friendly status if they meet the evidence-based '*Ten steps to successful breastfeeding*' (WHO, 1998).

There are a number of stages in the accreditation process (UNICEF, 2008):

- A Certificate of Commitment to mark the facility's commitment to work towards Baby Friendly accreditation. It assesses the breastfeeding policy and involves an implementation visit
- Stage 1 assesses policies and procedures
- Stage 2 assesses the staff education programme
- Stage 3 assesses the care provided to pregnant women and new mothers.

At the time of commencement of data collection (July 2009), United Lincolnshire Hospitals Trust had achieved stage 1 accreditation, having been awarded this in April 2007. The Trust achieved stage 2 accreditation in April 2011. Throughout the period of data collection, specific efforts were therefore being made within the local hospitals with regards to adherence to UNICEF BFHI *Ten Steps*, including provision of education in supporting breastfeeding for staff.

In the United Kingdom, a '*Seven Point Plan for Sustaining Breastfeeding in the Community*' (UNICEF UK Baby Friendly Initiative, 2008) (appendix 2) was introduced in 1998. It was developed to extend the principles of the

'*Ten Steps to Successful Breastfeeding*' (WHO, 1998) to cover the work of community health-care services. This extension of the initiative to community services was instigated following publication of evidence from the *Promotion of Breastfeeding Intervention Trial* (PROBIT) in Belarus which suggested that a primary care component was an important element in maintaining the increases in breastfeeding delivered by the maternity component (Kramer et al, 2001). UNICEF UK has also provided adapted versions for paediatric, neonatal services and universities (UNICEF, 2008). In Lincolnshire the local Primary Care Trust were awarded a certificate of commitment in November 2010, and stage 1 in September 2011.

Data from the Millennium Cohort study (Bartington et al, 2006) found that women giving birth in Baby Friendly accredited hospitals were 10% more likely to initiate breastfeeding compared to non-accredited units or units with a Certificate of Commitment. This concurs with data from a Scottish study which found that Baby Friendly accreditation increased breastfeeding rates by 8% at 7 days post birth (Broadfoot et al, 2005). However, the Millennium Cohort study found that being born in an accredited unit was not associated with increased breastfeeding rates at 1 month (Bartington et al, 2006). More recent evidence also questions the impact of BFHI on breast feeding duration (Beake et al, 2012). Schmied et al (2011) and Thomson et al (2012) suggest that if BFI is implemented in a top-down, performance driven manner this may result in rigid practices that are unlikely to meet the needs of women and their families. At present (2012), there are 87 UK hospital maternity units and 17 community healthcare facilities with full Baby Friendly accreditation (UNICEF, 2012). Locally, the hospitals Trust has achieved stage two Baby Friendly accreditation (in which staff knowledge and skills have been assessed as meeting a specific standard). Schmied et al (2001)

argued that '*professionalising*' (p45) breastfeeding may have negative consequences. The authors explored the potentially coercive nature of breastfeeding policies, and the somewhat rigid way in which these policies were imposed by midwives. Schmied et al (2001) suggested that breastfeeding is a highly complex phenomenon, and rather than a purely physiological process, it is a '*social, emotional or embodied experience where difficulties with breast feeding cannot always be resolved through clinical management that in the main, focuses on physiology*' (p48). Hoddinott et al (2012) suggest that the pass-fail nature of the BFI accreditation scheme may generate a right-wrong culture which does not facilitate mothers and health care professionals to work in partnership. Despite this debate, UNICEF UK Baby Friendly Initiative accreditation is widely promoted as a panacea to increase breastfeeding rates (for example NICE (2006) postnatal care guidance).

The Baby Friendly Initiative seeks to change the social and normative structure within an organisation in an effort to improve breastfeeding rates (Bilson and Dykes, 2009). The style of implementation of the BFHI is considered crucial to its adoption and maintenance, with an understanding of human emotions and relationships being central (Bilson and Dykes, 2009; Dykes and Flacking, 2010). However, BFHI is not accepted by all: a number of researchers have raised concerns regarding contradictions between the philosophical stance of the global approach to BFHI, and a tendency for health care professionals to focus on the '*Ten Steps*' as a rigid set of tasks or checklist to be accomplished (Schmied et al, 2011; Thomson and Dykes, 2011). Beake et al's (2012) systematic review reported evidence of an increase in initiation and short term duration from structured programmes such as the Baby Friendly Initiative. It is worth

noting that this increase was found in studies that had implemented programmes developed locally that did not reflect the BFHI content, or following the introduction of specific steps of the BFHI model, not solely the BFHI programme. Beake et al (2012) suggest that it may be that not all the '*Ten Steps*' of the BFHI model are needed to increase breastfeeding initiation and duration. Furthermore, evidence of an increase in initiation and short term duration is primarily from countries with a low baseline of breastfeeding rates. Whilst the BFHI model is of significance in low income countries because of the limited possibility of a relatively safe alternative to breastfeeding, the relevance to developed countries has been questioned. A recent survey undertaken by Brodribb et al (2013) of women in Australia found that, after adjustment for significant maternal, infant, clinical, and hospital variables, women who birthed in BFHI-accredited hospitals had significantly lower odds of breastfeeding at one month than those who birthed in non-BFHI-accredited hospitals. Baby Friendly accreditation did not affect the odds of breastfeeding at four months or exclusive breastfeeding at one or four months. It is not conclusive from Beake et al's (2012) review whether implementation of the BFHI supports sustained exclusive breastfeeding to six months. Barclay et al (2012) caution that a focus on institutional regulations and technical skills potentially reduces women's self-confidence. They suggest this may be a contributory factor in the lack of progress at improving rates of breastfeeding duration. When first introduced, the '*Ten Steps*' focused on changing institutionalised health care practices such as separation of mother and baby and supplementation. Practices such as offering all women skin-to-skin in the period immediately after the baby's birth, demand feeding and rooming in are now considered normal routine practice. It would seem timely to reconsider the approach offered in order to focus on supporting women who initiate breastfeeding to reach their

breastfeeding goals, to support women who wish to breastfeed exclusively to six months, and those who wish to continue breastfeeding to two years.

In England, the *NHS Plan* (DH, 2000), which outlined investment and reform in the National Health Service, stated the Government's increased support for breastfeeding to ensure a healthy start for children and to address inequalities in healthcare. The Acheson Report (DH, 1998), aimed at improving health and reducing health inequalities, suggested that interventions to promote rates of breastfeeding should decrease the incidence of infant infection and lead to other health gains for both mother and child. The Infant Feeding Initiative was subsequently launched in 1999 in England, as part of the government's commitment to improving health inequalities. The importance of breastfeeding was further highlighted by the inclusion of a specific target in the Department of Health's *Priorities and Planning Framework 2003-2006* (2002), '*increase of 2 percentage points per year in breastfeeding initiation rate, focussing especially on women from disadvantaged groups*'. The target aimed to reduce the inequality of health by diminishing the gap in breastfeeding rates between the affluent women and the deprived groups. This has recently been superseded by the *Public Health Outcomes Framework* (DH, 2012). *Every Child Matters* (Department for Education and Skills, 2004), the *National Service Framework for Children, Young People and Maternity Services* (DH, 2004) and the latest public health white paper (*Healthy Lives, Healthy People*, DH, 2010a) have re-emphasised the importance of initiatives to support breastfeeding.

'*Choice, access and continuity of care in a safe service*' was the commitment in the Department of Health's *Maternity Matters* policy document (DH, 2007).

Four national choice guarantees were made relating to choice about how to access maternity care, choice of type of antenatal care, choice of place of birth and choice of place of postnatal care. In relation to accessibility and integration of services in the community, this included recommendations for the development of stronger outreach midwifery support and breastfeeding services for vulnerable and disadvantaged families (p14). Together, these governmental policies provide a powerful context for local action to improve public health outcomes for children, young people and their families.

2.2.4 SUPPORT FOR BREASTFEEDING IN THE UNITED KINGDOM

2.2.4.1 Health care professionals

The International Confederation of Midwives (2011, p1) defines a midwife as a *'responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period'*. Midwives play a crucial role in helping women initiate and establish breastfeeding. The midwife has a statutory responsibility to provide postnatal care for not less than 10 days and for as long *'as the midwife considers necessary'* (NMC, 2012, p6). In Lincolnshire, following discharge home from the postnatal ward, community midwives offer selected home visiting. Mother and baby are usually discharged to the Health Visitor on the 10th day. Health visitors offer one initial home visit between 11-14 days, and universal contact as part of the child health promotion programme from 6-8 weeks. Ad hoc contact is via well baby clinic or on request.

McInnes and Chambers (2008) conducted a synthesis of qualitative research papers focusing on support for breastfeeding mothers. Health service support for women was described unfavourably due to staff time constraints, lack of staff availability, inadequate guidance, unhelpful practices such as physical intrusion, and conflicting advice. Studies have also explored the effects of length of postnatal stay in hospital on breastfeeding duration. Winterburn and Fraser (2000) conducted a randomised controlled trial in the United Kingdom to examine the effect of postnatal stay on breastfeeding. The results demonstrated no significant effect on breastfeeding rates at one month. This concurs with a Cochrane review which concluded that length of postnatal stay has no effects on early breastfeeding cessation (Brown et al, 2009). However, in a more recent qualitative longitudinal study, care during the hospital and early postnatal days was identified by women as the time of paramount importance for intense support, where continuity of care was valued (Hoddinott et al, 2010).

A number of exploratory studies have identified knowledge deficits among healthcare practitioners, ambivalent attitudes, inadequate skills and low levels of self-efficacy (personal confidence) in supporting breastfeeding women (Battersby, 2002; Furber and Thomson, 2008; Spear, 2006; Wallace and Kosmala-Anderson, 2007). Moreover, the failure of healthcare practitioners to provide consistent, adequate and appropriate postnatal support and education has been suggested (Dennis, 2002; Manhire et al, 2007; Spear, 2006) as one reason that may contribute to the early cessation of breastfeeding.

In the United Kingdom the profession of public health nurse (health visitor) was developed during the early decades of the twentieth century in response to concern about the welfare of infants in industrial towns (Dingwall et al, 1988). Public health practitioners have had a role in promoting and supporting breastfeeding for many years (Fairbank et al, 2000) but there is little evaluation of their impact on intention and duration (Renfrew et al, 2005a), and research suggests that they do not generally receive adequate training on breastfeeding (Tappin et al, 2006). Concerns were raised by the Education Committee of the Health Visitor's union (CPHVA) to the Nursing and Midwifery Council that breastfeeding education for those undertaking health visitor training remains inconsistent across the United Kingdom (Community Practitioner, 2008). Smale et al's (2006) study into the provision of breastfeeding education found that public health practitioners who were interested in breastfeeding pursued specific additional breastfeeding training rather than relying upon their standard initial training which was described by participants as '*variable*' or '*just the basics*' (p108). Furthermore, those practitioners who developed an interest in breastfeeding were not viewed as the norm but as zealots who were '*evangelical*' and '*fanatical*' (Smale et al, 2006, p109). There is a plethora of research conducted by midwifery-qualified researchers or concerning the role of the midwife and breastfeeding. Conversely, the role of the public health practitioners in breastfeeding promotion and continuation seems to have received sparse attention. Furthermore there has been an assumption among some public health practitioners that breastfeeding promotion in terms of positioning, demand feeding, cues that an infant is hungry and night-time feeding are all part of the remit of the midwife (Carlisle, 2008).

Against this background and the implementation of the Healthy Child Programme for under 5's (Department of Health and Department for Children, Schools and Families, 2009), the role of public health practitioners in breastfeeding requires further exploration. There has been recent debate on the lack of clarity about public health models and approaches to working, and use of the terms 'health visitor' and 'public health nurse' are often used interchangeably (Carr, 2005; Smith, 2004). It has been suggested that this confusion contributes to a lack of clarity on their workload prioritisation and potential for improving practice (Carr, 2005). Tappin et al's study (2006) is one of the few studies examining the role of public health practitioners in supporting breastfeeding. This study examined the health visitor's role in supporting breastfeeding in Glasgow, what was once one of the most deprived cities in Europe. Routine outcome data on breastfeeding was collected in 2000 via the Child Health Surveillance system, in addition to a postal questionnaire which was completed by 146 health visitors. The study suggests that babies who are breastfeeding at the first routine health visitor contact at 10 days are twice as likely to be breastfeeding at the second routine health visitor contact at 6 weeks if the health visitor had received training in breastfeeding in the previous two years. These results remained significant after controlling for socioeconomic variables and endorsed the importance of training.

2.2.4.2 Voluntary breastfeeding support

A Cochrane meta analysis of 34 randomised and quasi-randomised controlled trials published by Britton et al (2007) found that lay and professional support analysed together increased duration of any breastfeeding up to six months postpartum. Voluntary breastfeeding counsellors who have high

standards of practical training built into their curricula give invaluable support, but they should not be expected to fill the gaps in health service provision, education and training. A fundamental difference lies in the approaches offered by voluntary supporters. Breastfeeding information and support provided in hospital by midwives, is suggested to be commonly provided in a routine, prescriptive, authoritative and often rushed manner (Dykes, 2003). By contrast, voluntary supporters offer a person-centred, individualised approach that acknowledges the importance of a woman's experiential knowledge. Peer support programmes are advocated in NICE (2008) public health guidance to increase breastfeeding, especially amongst women with low incomes. However, a recent systematic review of evidence from randomised controlled trials concluded that peer support is likely to be ineffective for increasing breastfeeding rates in high income countries, in particular the United Kingdom (Jolly et al, 2012). The authors concluded that this may be the result of the amount of support for breastfeeding through routine health service postnatal care provision.

Breastfeeding help and support in the United Kingdom is also available via telephone helplines from agencies such as La Leche League, NCT, the Breastfeeding Network (BfN) and a National Breastfeeding Helpline which is run in collaboration with the Breastfeeding Network and the Association of Breastfeeding Mothers (ABM), funded by the Department of Health (Thomson and Crossland, 2013), and internet sources of peer breastfeeding support and advice such as Bosom Buddies and Mumsnet.

2.2.5 FACTORS INFLUENCING EARLY CESSATION OF BREASTFEEDING

A number of factors have been identified in the literature as being associated with early cessation of breastfeeding. Some of the demographic variables are well established and reflect those variables affecting initiation of breastfeeding (socio economic group, age, education, marital status, ethnicity and support networks). In addition, a number of biological factors that affect lactogenesis II were identified (such as maternal obesity, birth of a very pre term infant), and these have been excluded from this discussion. However, there are a number of additional variables influencing early cessation of breastfeeding, all of which are summarised in the following table and will be discussed in turn. These variables can be broadly divided into four groups: demographic, biological, psychological and social.

Demographic	Biological	Social	Psychological
Socio economic group	Factors affecting lactogenesis II	Maternal return to work intentions	Maternal identity
Age	Insufficient milk supply	Cultural context and prior exposure to breastfeeding	Maternal motivation and commitment
Education	Breastfeeding difficulties (such as sore nipples)	Public feeding	
Marital status	Maternal smoking	Use of pacifier	
Ethnicity	Parity		
Support networks			

Table 2: Variables influencing early cessation of breastfeeding

2.2.5.1 Insufficient milk supply

The most frequently cited reason women give for stopping breastfeeding is insufficient milk supply (Binns and Scott, 2002; Bolling et al, 2007; Cooke et al, 2003; Dykes and Williams, 1999; Dykes, 2005; Hauck et al, 2011; Ho and McGrath, 2011; Manhire et al, 2007; Mozingo et al, 2000). Research reports present insufficient milk syndrome as incorporating a complex range of biological, physiological, cultural and iatrogenic components (Dykes and Williams, 1999; Dykes, 2005). An expectation of failure was a predominant feature in women's accounts, with women talking of their anxieties about their milk production (Dykes and Williams, 1999; Dykes, 2005; Manhire et al, 2007; Mozingo et al, 2000). In Bailey's (2007) doctoral study of a convenience sample of mothers and their partners, all of the couples wanted their babies to be happy and healthy and weight gain was considered to be significant. The perception that a big baby equated to a happy and healthy baby coupled with the belief that a big baby could not thrive on breast milk alone led to formula milk being perceived as good. Women report deep-rooted negative feelings about the adequacy and sufficiency of their breast milk, and a profound lack of confidence in their ability to breastfeed. In response to perceived insufficient milk supply, mothers provide their baby with supplementary formula milk. Supplementary bottle feeds before discharge from hospital have been found in three published studies to be associated with early cessation of breastfeeding (Forster et al, 2006; Scott et al, 2006; Wright et al, 2006).

In a cross-sectional descriptive study of 60 women, McCarter-Spaulling and Kearney (2001) found a significant correlation between perceived insufficient milk supply and low maternal self-efficacy in early weeks of breastfeeding.

They concluded that women who believe they are able to breastfeed and to deal with any breastfeeding challenges perceive sufficient milk supply. However, those women who doubt their breastfeeding ability may perceive insufficient milk supply and start supplementary feeding. An anticipation of failure and lack of self-confidence has been demonstrated to lead participants to seek advice from professionals and peers, in addition to attending clinic for regular weighing to ascertain their infant's progress (Dykes and Williams, 1999; Manhire et al, 2007).

2.2.5.2 Breastfeeding difficulties

Breastfeeding difficulties is a phenomena identified clearly in the published literature (Brand et al, 2011; Dykes, 2005; Flower et al, 2008; Manhire et al, 2007; Mozingo et al, 2000). Those women who experienced breastfeeding difficulties and whose experience was not as anticipated, expressed feelings of failure and self blame (Bailey et al, 2004; Dykes, 2005; Hall and Hauck, 2007; Hauck and Irurita, 2003; Manhire et al, 2007; Mozingo et al, 2000).

2.2.5.3 Maternal smoking

Maternal smoking has been cited as influencing early cessation of breastfeeding (Gerd et al, 2012; Scott et al, 2006). Scott et al (2006) found that smoking was strongly associated with discontinuation of breastfeeding by 10 weeks postpartum. Liu et al (2006) examined the association between maternal smoking and breastfeeding duration before, during and after pregnancy. After controlling for co-founders, persistent smokers (those mothers who smoked before, during and after pregnancy) were 2.18 times

more likely to not breastfeed at 10 weeks.

2.2.5.4 Parity

There have been numerous studies exploring breastfeeding and parity. However, the results are not conclusive: some researchers have reported a longer duration of breastfeeding amongst multiparous women (Haas et al, 2006). Other research has failed to show a significant relationship between increased parity and duration of breastfeeding (Ekstrom et al, 2003). There was a significant difference between parity reported by Hauck et al (2011), with more primiparous than multiparous women ceasing their breastfeeding by nine weeks. However, it is interesting to note that dividing the time of cessation into specific time spans demonstrates interesting trends. The majority of women ceased breastfeeding before five completed weeks. The period between 1 and 2 weeks had the highest numbers of multiparous women stopping breastfeeding. Primiparous women continued to breastfeed for longer, with more primiparous women ceasing at 3-4 weeks.

2.2.5.5 Maternal return to work intentions

The effect of a return to work has been found in several studies to be associated with early cessation of breastfeeding (Bick et al, 1998; Gatrell, 2007; Taveras et al, 2003; Walburg et al, 2010). As part of a study into long term postpartum health, 906 women who had given birth at a large maternity hospital in Birmingham were interviewed at a mean of 45 weeks after birth (Bick et al, 1998). The authors determined that the strongest predictor of early cessation was a return to work within three months of

giving birth. Gatrell (2007) explored through in-depth interviews the experiences of 20 mothers in the United Kingdom who returned to professional employment within 1 year of childbirth. In order to comply with workplace requirements, mothers in her study were obliged either to cease breastfeeding or to conceal breastfeeding activities.

2.2.5.6 Cultural context

The decision to breastfeed or formula feed is profoundly influenced by cultural norms (Dykes and Flacking, 2010). Prior exposure to breastfeeding as an infant feeding method has been stated as influential in women's decisions to persevere with breastfeeding (Hoddinott and Pill, 1999). However, the United Kingdom has a predominately bottle feeding culture, and therefore although the majority of women in the synthesised literature expressed the view that breastfeeding was nutritionally superior for their infant, they anticipated breastfeeding could '*go wrong*' (Bailey et al, 2004, p240) and were therefore resigned to giving breastfeeding a '*try*' (Hoddinott and Pill, 1999) before moving on to formula feeding if they encountered problems. Bailey and Pain (2001) and Pain et al (2001) concluded that infant feeding decisions and practices are contextualised in parents' personal, social, cultural and geographical circumstances.

2.2.5.7 Public feeding

Breastfeeding in public was a recurring theme in the published studies (Earle, 2000; Flower et al, 2008; Hoddinott and Pill, 1999; Mahon-Daly and Andrews, 2002; Raisler, 2000; Stearns, 1999). A small number of women have also expressed discomfort feeding in front of their partner (Scott et al,

2006) or other children (Stewart-Knox et al, 2003). Women either stopped breastfeeding altogether because of this concern, or fed in seclusion (Sheeshka et al, 2001; Stewart-Knox et al, 2003). This has the added effect of further marginalising breastfeeding as an infant feeding method (Stewart-Knox et al, 2003).

2.2.5.8 Use of pacifier

Use of a pacifier (dummy) has also been associated with early cessation of breastfeeding (Feldens et al, 2012; Forster et al, 2006; Scott et al, 2006). Scott et al (2006) found that the introduction of a pacifier in the first 10 weeks increased the risk for the cessation of full breastfeeding by 6 months and overall breastfeeding by 12 months. Breastfeeding duration, however, was not significantly affected when a pacifier was introduced after 10 weeks. It has been suggested that the decrease in breastfeeding duration associated with pacifier use may be the consequence of less frequent episodes of breastfeeding (Forster et al, 2006; Gerd et al, 2012).

2.2.5.9 Maternal identity, motivation and commitment

Women demonstrate a strong conviction that breastfeeding is best for babies, while breastfeeding is considered synonymous with being a good mother and a woman's identity or sense of self as a mother (Earle, 2000; Hauck and Irurita, 2003; Hoddinott and Pill, 1999; Mozingo et al, 2000; Raisler, 2000; Stearns, 1999). This narrative was a powerful motivator to persevere with breastfeeding when experiencing difficulties (Cooke et al, 2003; Hauck and Irurita, 2003; Mozingo et al, 2000; Raisler, 2000). Using a sample of 271 first-time mothers in Finland, Tarkka et al (1999) found

that women coped better with breastfeeding when they felt compelled as mothers to breastfeed, and felt an appreciation of breast feeding in society. Bailey (2007) deemed confidence and determination necessary for continued breastfeeding.

There is ongoing debate about how to reduce breastfeeding cessation rates. Ingram et al (2002) conducted a study in Bristol in which a 'hands-off' breastfeeding technique was taught to hospital midwives and health care assistants. This technique was then taught to mothers in the study from their first breastfeed. Mothers with high scores for hands off technique were significantly more likely to be breastfeeding at six weeks. The incidence of mothers feeling that they did 'not have enough milk' decreased significantly after the breastfeeding technique had been taught.

MacArthur et al (2003) investigated the use of evidence-based guidelines as a component of postnatal care provided by midwives in the West Midlands over an extended duration. One guideline in this cluster randomised controlled trial related to breastfeeding. No statistically significant differences in breastfeeding rates were detected at 4 or 12 months, or in the mean number of days feeding (MacArthur et al, 2003, p35).

2.2.6 SOCIAL SCIENCE PERSPECTIVES

Breastfeeding has been described by various authors from a variety of theoretical perspectives. This sub section provides a brief overview of some of the anthropological, feminist and sociological literature that contribute to understandings of the phenomenon of breastfeeding.

Anthropological perspectives draw attention to attitudes towards breastfeeding in societies where bottle feeding is more common. The promotion of breastfeeding in hospital encourages new mothers to begin breastfeeding. However at home, mothers may turn to infant formula as this is how their community sees infant feeding - milk in bottles (Amir, 2011). The majority of women in Lee's study of mothers' experiences of formula milk use in the early weeks experienced '*formula feeding as a pragmatically advantageous option for feeding babies*' (2007, p1086).

According to Dykes (2005), there has been relatively little anthropological focus on infant feeding practices within the United Kingdom. Two ethnographic studies conducted in the UK have explored issues relating to breastfeeding. Cloherty et al (2004) focused on issues around supplementation of breastfed babies on the postnatal ward by health care professionals with infant formula. The authors determined midwives' desire to protect the mothers from tiredness or distress, although this at times conflicted with their role in promoting breastfeeding. Dykes (2005) undertook an ethnographic study exploring influences upon women's experiences of breastfeeding within the postnatal ward setting. The women

conceptualised breastfeeding using metaphors of the industrial production line with its notions of supply and demand. Both of these studies highlighted issues in breastfeeding management and support relating to time constraints within hospital-based postnatal practice.

Feminist writers situate women's experiences in relation to power, politics, gender differences and inequality (Carter, 1995; Hausman, 2012; Stearns, 2009). Schmied and Lupton (2001) undertook a study of first-time parenthood in Australia. A series of semi-structured interviews was carried out with 25 women from late pregnancy until three years from the birth of their first child. Some of the women experienced breastfeeding as a connected, harmonious and intimate relationship between themselves and their baby. For the majority, however, the breastfeeding relationship between mother and infant was difficult to reconcile with notions of identity that value autonomy, independence and control.

Tension between the sexual and the maternal breast has been highlighted by Bailey and Pain (2001, p31). Kitzinger (2005, p41) comments that women who breastfeed in public may be accused of '*distasteful behaviour*' and failure to '*conform to normal standards of decency*'. Young (2005) concurs, commenting that the social contempt shown to women who breastfeed in public reflects anxieties about the sexual potential of breastfeeding. She also notes that men may resent the attachment of female babies to their breastfeeding mother.

Feminist writers have argued that breastfeeding promotion efforts ignore the material realities of women's lives (Rosin, 2009; Wolf, 2010). Carter (1995) notes there is a relative lack of feminist discussion of breastfeeding. According to Carter, this absence may be attributed to one of the central dilemmas of feminism:

should women attempt to minimize gender differences as the path to liberation or should they embrace and enhance gender difference through fighting to remove the constraints placed on them by patriarchy and capitalism, thus becoming more "truly" women? One might see bottle feeding as freeing women from the demands and restrictions of lactation or, on the other hand, as imposed on women by the manufacturers of baby milk depriving them of a unique womanly experience, based on centuries of skill and knowledge (Carter, 1995, p14).

Feminist writers and sociologists have argued that the responsibility for early infant nurture / nutrition impacts particularly upon women as mothers (Murphy, 1999). Sociological perspectives such as social status and social networks, kinship and social forces are all concepts that have been applied to the phenomenon of breastfeeding. Health has attained increasingly moralised connotations. Breastfeeding is conceptualised as the gold standard (Knaak, 2005). The reiteration of the health benefits of breastfeeding alongside sociocultural ideologies of motherhood reinforce an implicit connection between breastfeeding and the good mother (Murphy, 1999; Hausman, 2012). In one of the few studies of the experiences of formula feeding mothers, Lee (2007) suggests that a woman has to

undertake identity work if she is to respond to the moralisation of infant feeding whereby she places her own needs and preferences above her baby's welfare needs.

Breastfeeding is interpreted against a backdrop of culturally-mediated ideologies. Anthropological, feminist and sociological inquiry have all contributed to the literature on the phenomenon of breastfeeding. However, these approaches have failed to account for the individually located experience of breastfeeding.

2.3 REVIEW OF THE LITERATURE ON UK WOMEN'S EXPERIENCES OF BREASTFEEDING

The aim of this study was to investigate the phenomenon of breastfeeding, by exploring women's experiences of breastfeeding. The evidence base for the phenomenon of breastfeeding spans a broad range of topic areas. A narrative approach to the synthesis was used, with quality appraisal guided by Walsh and Downe (2006). It is generally accepted that a Cochrane Collaboration systematic review offers the most robust form of evidence, however the focus of such reviews can be narrow (Collins and Fauser, 2005). Narrative synthesis methods of systematic review facilitate understanding and acknowledgement of the broader influences of contextual and theoretical variables (Pope et al, 2007). Narrative synthesis involves the juxtaposition of findings from the included studies with an element of interpretation and/or integration.

The databases ASSIA Applied Social Sciences Index and Abstracts, Cumulative Index to Nursing Allied Health Literature (CINAHL), Maternity and Infant Care, OVID MEDLINE, EMBASE, the Joanne Briggs Institute EBP database, PsycINFO, ScienceDirect and WEB of Science were used. A broad initial literature search was undertaken using the keyword or MeSH heading 'breastfeeding' (breastfe*, breast-fe*, breast fe*). The inclusion criteria were set at publications in English language. No time limits were set. This yielded 80086 papers, including one meta synthesis, focusing on the experiences of women in developed countries (Nelson, 2006). Repeating the same broad search in May 2012 obtained an additional meta synthesis on women's experiences of breastfeeding (Burns et al, 2010).

Nelson (2006) synthesised 15 qualitative research papers on maternal breastfeeding experience: eight conducted in the United States, four in Australia, two in Canada, and one in the United Kingdom. In total, her metasynthesis represented cumulative data from a total of 247 participants. Nelson presented her meta synthesis findings using quotes from the women in the original studies. She described the phenomenon of breastfeeding as '*an engrossing, personal journey*' (p15). This interpretation is supported by findings related to the concerted, sustained maternal effort when learning how to breastfeed and overcome obstacles. The intense emotional nature of the mother-child relationship in breastfeeding and the maternal adaptation required followed by a subsequent need for resolution were also identified as sub themes. There are however some incongruences in Nelson's (2006) paper: for example she states that her search was limited to publications within the preceding 10 years, yet included papers published from 1990 to 2003. Her search was also inclusive of '*broad aspects of the maternal experience*' (p14), yet

her underpinning aim was to explore breastfeeding as the central experience.

Burns et al (2010) undertook a secondary analysis of language to explore the motivation, restrictions and practices of breastfeeding women in their meta-ethnographic synthesis. The authors retrieved 236 papers that reflected women's experiences of breastfeeding, again limiting their search to qualitative research only. They utilised an approach to the synthesis as advocated by Noblit and Hare (1988), and deemed to have reached saturation after 17 papers had been synthesised. Of these 17 studies, one reported the open-ended responses to a questionnaire (Manhire et al, 2007), and the remaining studies used interviews or focus groups as the data collection method. This meta-ethnographic synthesis represented the experiences of over 500 women in six Western countries. Two main themes were identified: '*expectations and reality*' (p205) in which women expected breastfeeding to be a natural process and best for baby and aligned with being a good mother. In reality, breastfeeding was demanding and required perseverance. The second overarching theme was labelled '*discourses of connection and of disconnected activity*' (p205). Women expressed an overwhelming sense of achievement, joy and pride. Conversely, some women experienced breastfeeding as a negative activity, in which their body was out of control, the baby did not know how to feed and potential support people were '*very unhelpful*' (p211).

The number of studies included within a synthesis is an issue of debate. Whilst the included studies need to provide depth of insight into the research question, too many may hinder the data analysis process (Bondas

and Hall, 2007). A balance is required. In practice, the number of studies included is usually relatively small. Bondas and Hall (2007) suggest between 8 and 13 studies. I decided to focus on publications within the preceding five years from the initial search date (March 2008). This date was selected as a cut off as it was important to focus primarily on the phenomenon of breastfeeding as it has been experienced in recent years, given the pace of change in health care service provision and policy. Search term 'breastfeeding' (breastfe*, breast-fe*, breast fe*) was further refined with the query string of experience*. These terms were taken from keywords identified in relevant papers. This component of the literature search was initially conducted in March 2008 and repeated in May 2012. A decision was made to focus this review specifically on the experiences of women living in the United Kingdom only as providing the most useful and relevant information given the contextual nature of this study. The limits set were:

- breastfeeding as a central concept
- articles addressing the experiences of women / mothers
- human
- articles written in English language
- studies conducted in the United Kingdom
- published from 2003 onwards

The following section provides a comprehensive description of all the search strategies utilised:

ASSIA

The ASSIA database was searched using the advanced search function, inputting the search terms and Boolean operators. 56 hits were initially generated with 10 articles identified for possible inclusion in 2008. The search was repeated in 2012 and obtained 16 further hits, and 5 further articles identified for initial review.

CINAHL Plus with full text (EBSCO)

The CINAHL Plus database was searched by inputting the search terms and Boolean operators. Limitations of breastfeeding as a major heading, full text, English language, peer reviewed, publication since January 2003, and human were applied. The advanced search screen was utilised and 14 hits were initially generated in March 2008, with 4 possible relevant articles. A subsequently updated search in May 2012 identified a further 24 articles, of which 9 were deemed potentially relevant.

Maternity and Infant Care, OVID MEDLINE, EMBASE, the Joanne Briggs Institute EBP database, and PsycINFO

These databases were searched via the University elibrary, by inputting the search terms and Boolean operators. Limitations of breastfeeding as a major heading, full text, English language, peer reviewed, publication since January 2003, and human were applied. The advanced search screen was utilised and 136 hits were initially generated in March 2008, with 2 possible relevant articles. A subsequently updated search in May 2012 identified a further 36 articles, of which 12 were deemed potentially relevant.

ScienceDirect

The Science Direct database was searched using the advanced search function, inputting the search terms and Boolean operators. 53 hits were initially generated with 8 articles identified for possible inclusion in 2008. The search was repeated in 2012 and obtained 115 further hits, and 13 further articles identified for initial review.

WEB of Science

The WEB of Science database was searched by inputting the search terms and Boolean operators. Limitations of breastfeeding as a major heading, full text, English language, publication since January 2003, and human were applied. 38 hits were initially generated in March 2008, with 7 potential articles for inclusion. A subsequently updated search in May 2012 identified a further 144 articles, of which 15 were deemed potentially relevant.

The reference lists of reviewed articles were also searched for relevant citations, and the National Research Record Archive and the National Institute for Health Research Clinical Research Network Portfolio (followed by PubMed searches for published research results), yielding two further studies.

The 87 papers were pre-screened. After eliminating 44 duplicates, abstracts were screened from the remaining 43 articles. Sub groups of studies were then excluded whose scope was limited to infant feeding decision-making,

attitudes towards breastfeeding, professional breastfeeding support, and breastfeeding practices under special circumstances such as with a very preterm infant, HIV positive mothers, or women with endocrine disorders because the establishment of breastfeeding and lactogenesis II might be compromised in such populations (Hartmann et al, 2003).

After the exclusion of the subgroups identified, a total of 11 eligible studies were finally included (list of included studies in appendix 3). A flowchart of the process of selecting the included papers is shown in Figure 1 (overleaf).

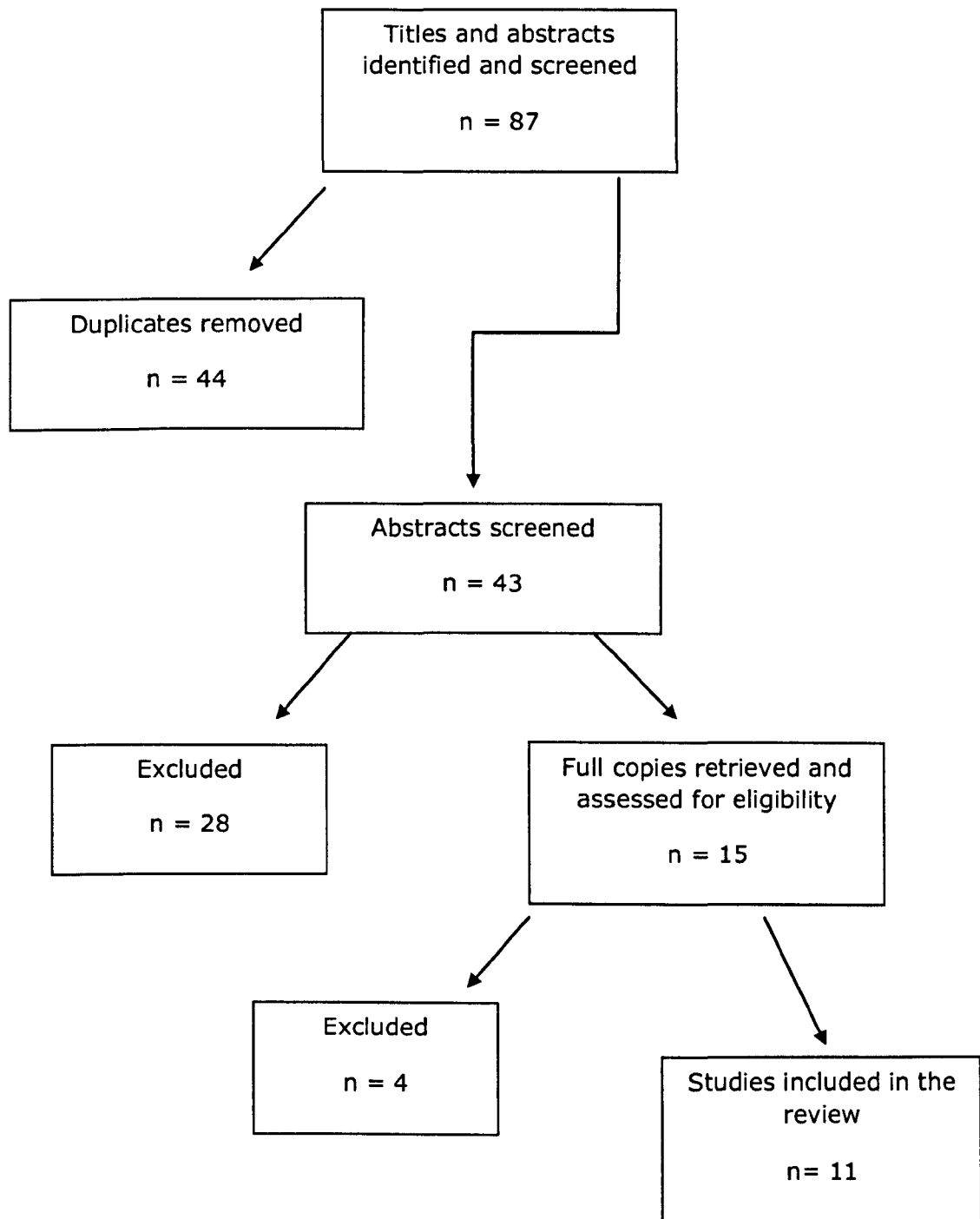


Figure 1: Flowchart of the process of selecting the included papers

This review of the literature was not intended to be a systematic review due to the large volume of literature available and the limitations of resources undertaking a part-time doctoral programme. However, it has

been conducted using a systematic approach, and has concentrated primarily on the literature relevant to the aim of the study, with emphasis on the empirical research relating to women's experiences of breastfeeding.

In total, the number of hits obtained from the two searches was 632. 87 abstracts related to breastfeeding. Following abstract screening, data extraction of full text articles, and application of the inclusion criteria, 11 articles remained (6 from the first search, and a further 5 from the updated search). The application of quality criteria to qualitative research is widely debated, although many accept the need for clear and transparent approaches for judging the quality or credibility of research. Despite lack of consensus about quality assessment a number of different tools and techniques are available. For this study, this was undertaken applying the criteria suggested by Walsh and Downe (2006) which consists of a set of prompts relating to 8 key areas: scope and purpose; design; sampling strategy; analysis; interpretation; reflexivity; ethical dimensions; relevance and transferability. Comments relating to these concepts and thereby identifying strengths and limitations of the reviewed papers are included in the table in appendix 3. After data extraction, each paper was listed in a table detailing the authors, year of publication, methods, participants and results as described by the authors of the paper (appendix 3). Each paper was then revisited, as advocated by Walsh and Downe (2005), and key themes extracted from the findings. This allowed for both descriptive and narrative synthesis to occur. The themes were identified through quotations by participants or comments by the authors about their data, and not from references to other published literature.

Breastfeeding has been researched in the UK by a number of researchers from a variety of disciplines. This indicates the multi-faceted nature of the phenomenon of breastfeeding. Studies have been conducted using a number of methodological approaches, such as ethnography (Dykes, 2005), although in one of the published studies this was not described (Bailey, 2007). In turn, different methods have been utilised, such as focus groups (Dykes et al, 2003), participant observation (Dykes, 2005), questionnaires (Redshaw and Henderson, 2012), interviews (Bailey et al, 2004; Bailey, 2007; Gatrell, 2007; Hoddinott et al, 2012; Marshall et al, 2007; Ryan et al, 2011; Thomson and Dykes, 2011), or mixed methods (Choudhry and Wallace, 2010).

Some studies set out explicitly to explore women's experiences of breastfeeding, whereas others analysed feeding-related responses from studies of the postnatal experience (Redshaw and Henderson, 2012), the effects of acculturation on breastfeeding intentions and practices (Choudhry and Wallace, 2010), or the influence of combining paid work with breastfeeding (Gatrell, 2007). One study collected data in the first few postnatal days whilst on the hospital postnatal ward (Dykes, 2005). Some sampled women purposively from areas of socioeconomic deprivation (Bailey et al, 2004; Hoddinott et al, 2012). Only one study included participants from a rural area (Marshall et al, 2007). One study recruited a convenience sample from friends and family (Bailey, 2007). Different methods of data analysis were utilised, including thematic networks analysis (Dykes et al, 2003; Dykes, 2005; Thomson and Dykes, 2011) and Interpretive Phenomenological Analysis (Bailey, 2007). Two studies utilised specific theories as conceptual lens to analyse their data (Choudhry and Wallace, 2010; Thomson and Dykes, 2011).

Three themes emerged from the synthesis of the included studies, reflecting the three foci of the phenomenon of breastfeeding in the current literature: bio-psycho-social:

2.3.1 Biomedical aspects

A biomedical discourse was a recurrent sub theme throughout many of the recently published studies. Dykes (2005) conducted an ethnographic study in two maternity units in two hospitals in the North East of England between 2000-2001. Data was obtained of 61 women's experiences within postnatal wards. Participant observation was also undertaken of 97 encounters between midwives and postnatal women, 106 focused interviews with postnatal women and 37 '*guided conversations*' (p2283) with midwives. The themes identified (providing, supplying, demanding, controlling) all relate to women's experiences of breastfeeding as a productive project. This study presents an insight into women's conceptualisation of breastfeeding during the first few days after birth whilst still on the postnatal ward. These women conceived breastfeeding as a production line, with a dualistic viewpoint of their bodies as vessels that were apart from them, with the task of breastfeeding as one-way, demanding and in need of control and supplementation. Lack of time and support women were afforded on the postnatal ward in supporting breastfeeding was also identified in Thomson and Dykes' (2011) evaluation study. This was one of only two of the included studies which specifically included consideration of the impact of BFI accreditation (in this study, to evaluate the implementation of the BFI Community Award within two primary care Trusts in North West England).

2.3.2 Sociocultural aspects

The influence of culture on breastfeeding experiences seems to be a recurrent theme. A 'give it a go' breast-feeding culture was identified in Bailey et al's (2004) study, where women who intended to breast feed had a strong expectation of difficulties and even failure. These expectations of failure seemed to stem from a lack of exposure to breastfeeding as the norm as an infant feeding method, and a pervasive bottle feeding culture in which it was assumed that difficulties would be encountered with breastfeeding. Bailey et al (2004) go further to suggest that '*failing at breastfeeding is becoming the norm*' (p248). This dominance of a bottle feeding culture and negative media images were also identified by Thomson and Dykes (2011) as influencing the meaningfulness of breastfeeding to women. Using Antonovsky's (1979) 'Sense of Coherence' theory, Thomson and Dykes (2011) explored how infant feeding was influenced by the comprehensibility, manageability and meaningfulness of this event through semi-structured interviews with 15 women who were between 1 and 9 months postpartum, who had all initiated breastfeeding at the birth of their youngest baby. Although a small study from one geographical area, this study provides a unique perspective on socio-cultural influences on women's experiences of infant feeding.

A mismatch between expectations and experience has been identified in two recently published studies. In Hoddinott et al's (2012) qualitative, serial interview study undertaken in Scotland, there was a clash between overt or covert infant feeding idealism and the reality experienced. Pivotal points were identified where families perceived that the only solution that would restore family well-being was to stop breast feeding or introduce

solids. Immediate family well-being was the overriding goal rather than theoretical longer term health benefits. Similarly, a national survey of women's experience of maternity care in England undertaken by Redshaw and Henderson (2012) also identified the mismatch between women's expectations and experiences.

Choudhry and Wallace (2010) conducted a study exploring the impact of acculturation. Women displaying low acculturation levels were aware of living in a formula-feeding culture but this had little influence on breastfeeding intentions/behaviours, drawing upon South Asian cultural teachings of the psychological benefits of breast milk. These women opted to formula-feed in response to their child's perceived demands or in a bid to resolve conflict; either when receiving information about the best feeding method or between their roles as a mother and daughter-in-law. Highly acculturated women also experienced such conflict; their awareness of the formula-feeding culture governed feeding choice.

Breastfeeding was perceived as an activity that was incongruous with paid employment (Bailey, 2007; Gatrell, 2007). Gatrell's (2007) study of twenty women who returned to employment within 1 year of childbirth found that breastfeeding was viewed as 'taboo' in the workplace. Working mothers were therefore obliged to cease breastfeeding or conceal breastfeeding activities.

Breastfeeding in public was also a common theme in the studies. Women's embarrassment seems to be based largely on concerns about exposing their

breasts in public but also exposing their breasts to midwives and health visitors when requiring support is an issue for some women too (Ryan et al, 2011).

2.3.3 Psychological aspects

Women's expectations and experiences of breastfeeding have a varied psychological impact on their wellbeing, identity and perceptions of role. Dissonance and division appear where incompatibility between expectation and experience occur. Findings from a study conducted in the North of England by Marshall et al (2007) questioned the concept of breastfeeding as synonymous with being a 'good mother'. Marshall et al's (2007) qualitative study included observation of 158 interactions between breastfeeding women and midwives and health visitors in a community setting and in-depth interviews with a sub sample of 22 women and 18 health professionals. Marshall et al (2007) reported that participants made their infant feeding decisions in a context shaped not solely by expert discourses but by the practical realities of their daily lives and their '*pre existing identities as women, wives and workers*' (p2157).

A desire to share accountability and the infant feeding experience with partners which led to introduction of formula feeding was a core theme in two of the studies (Bailey, 2007; Dykes et al, 2003). However, those women who stopped breastfeeding before they had planned to expressed feelings of intense and sustained grief, sorrow and guilt (Bailey et al, 2004). A strong determination to succeed was commonly expressed by participants across studies who continued to breastfeed despite reporting difficulties (Bailey, 2007).

A growing body of literature from recent studies into women's experience of breastfeeding is generating interest in the concept of reciprocity. Ryan et al (2011) undertook a qualitative study utilising in-depth video interviews with 49 women who were breastfeeding or had done so in the previous two years. Three dimensions to the breastfeeding experience were identified: calling, permission, and fulfilment. 'Calling' is characterised as nonverbal communication between mother and baby, the woman's body knew and acted immediately and intimately before she had time to reflect. 'Permission' refers to the uninterrupted and protected space in which breastfeeding takes place and the women described 'fulfilment' in terms of the closeness, comfort, and bodily compatibility of successful breastfeeding.

2.4 SUMMARY

In this chapter, breastfeeding as a phenomenon has been explored. A large body of literature has explained breastfeeding in terms of the physiological processes. The health benefits for both infants and mothers in developed countries have been described in section 2.2.1. It appears that findings of neutral or negative impacts of breastfeeding on the health of infants are unreported. Whether the under-reporting of these findings is a result of publication bias, or the powerful public health drive to improve breastfeeding rates, is uncertain (Horta et al, 2007). It is from this biomedical paradigm that policies and strategies to promote breastfeeding have been derived. These were outlined in section 2.2.3. Breastfeeding is interpreted against a backdrop of culturally-mediated ideologies. Factors

affecting early breastfeeding cessation, outlined in section 2.2.5, identify insufficient milk syndrome as the most frequently cited reason women gave in the reviewed literature for stopping breastfeeding (Binns and Scott, 2002; Bolling et al, 2007; Cooke et al, 2003; Dykes and Williams, 1999; Dykes, 2005; Hauck et al, 2011; Ho and McGrath, 2011; Manhire et al, 2007; Mozingo et al, 2000). Contemporary writers in the United Kingdom have demonstrated that the phenomenon of breastfeeding is a biomedical, sociocultural and psychological phenomenon.

There are still considerable gaps in our knowledge, especially in a United Kingdom context. There is a strong focus on breastfeeding as a health issue, but its place in the broader sociological picture has largely been neglected. Despite an increasing research base about what helps or hinders breastfeeding, there is a dramatic drop in breastfeeding prevalence within the first six weeks (EMPHO, 2012; HSCIC, 2012). The reasons that mothers give for stopping breastfeeding suggest that few mothers gave up because they planned to, particularly those giving up before four months (Bolling et al, 2007). Most importantly, given that breastfeeding confers short and long term health benefits for both mother and infant, and the adverse effects of early discontinuation, particularly to maternal mental health and attachment security between infant and mother, it is crucial that more research is directed to capturing, analyzing, and seeking to understand this phenomenon from the perspective of those living that experience.

NICE (2006) public health guidance recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS. Evidence supports the provision of a combination of interventions including antenatal

education, peer support and education and training for health care professionals (Britton et al, 2007; Renfrew et al, 2005b). The evidence underpinning the UNICEF BFI standards is epidemiological and biomedical: focused on increasing breastfeeding rates (Kramer et al, 2001; Broadfoot et al, 2005). There has been a widespread increase in BFI accredited maternity units, community health services, pre registration and post registration programmes for health care professionals. There is however, little sociological analysis to demonstrate impact on the organisation, professionals or women who experience care in an accredited unit. Whilst the rate of initiation of breastfeeding has shown a steady increase over this time period, rates of exclusive breastfeeding in the early weeks and months has shown only marginal increases nationally (HSCIC, 2012). Of significance, the prevalence of breastfeeding at 6-8 weeks in Lincolnshire shows a decreasing trend over the last four years (EMPHO, 2012). Whilst there has been an increase in qualitative research studies exploring breastfeeding, many of these studies have been concerned with infant feeding decision-making, attitudes towards breastfeeding, initiation, breastfeeding support, and breastfeeding practices of specific cultural groups or under special circumstances such as with a preterm infant.

The influence of postnatal care provision requires further exploration. Results from a randomised controlled trial conducted in the United Kingdom (Winterburn and Fraser, 2000) demonstrated no significant effect on breastfeeding rates at one month. A Cochrane review concurred (Brown et al, 2009). However, care during the hospital and early postnatal days was identified by women in a more recent longitudinal study as the time of paramount importance for intense support, where continuity of care was valued (Hoddinott et al, 2010). Tappin et al's (2006) study examining the

role of public health practitioners in supporting breastfeeding suggested that babies who are breastfeeding at the first routine health visitor contact at 10 days are twice as likely to be breastfeeding at the second routine health visitor contact at 6 weeks, if the health visitor had received training in breastfeeding in the previous two years. To reiterate, in Lincolnshire at the time of commencement of data collection (July 2009), the acute Trust had achieved stage 1 accreditation, and were striving towards stage 2 accreditation in providing staff breastfeeding education programmes. The local Primary Care Trust (who employ public health practitioners) were not BFI accredited during the period of data collection, although they have since been awarded a certificate of commitment, and achieved stage 1 in September 2011. The importance of service user experiences, and integrating these into service developments have been identified as key components of high quality care. Lord Darzi's report *High Quality Care for All* (2008) highlighted the importance of service user experience within the NHS. The government white paper *Equity and Excellence: Liberating the NHS* (DH, 2010b) signalled that more emphasis needed to be placed on improving service user experience of NHS care.

Understanding the journey a mother makes from starting to breastfeed to cessation may help to identify more effective and appropriate support mechanisms. By contrasting and comparing these mothers' experiences against the backdrop of the existing breastfeeding literature, this study aimed to move us one step further towards the development of a comprehensive understanding of the phenomenon of breastfeeding.

The following gaps have thus been identified in the current evidence base:

- Few studies have been conducted in rural geographical areas of the United Kingdom.
- Few studies have explored the experiences of women after the initial postnatal period: those who continue breastfeeding and those who discontinue.
- Few studies have been conducted since the increase in BFI accredited health services and BFI accredited pre and post registration health care professional training (no studies that were published in the earlier search undertaken in March 2008 were conducted in Maternity Units or community healthcare services that were BFI accredited).

The next chapter provides a detailed description of the philosophical underpinnings, the research methods employed and how rigour has been achieved in this study of women's experiences of breastfeeding.

CHAPTER 3

METHODOLOGY AND METHODS

3.1 INTRODUCTION

This chapter presents the methodology and methods chosen for this research study. This chapter is thus concerned with the question the research study set out to answer, and the design used to answer this question. The relationship between research question and study design is fundamental to the quality of the whole research process. The chapter thus provides a detailed description of the philosophical underpinnings and design of this research study.

Review of the literature relating to breastfeeding identified that there is a wealth of knowledge on biomedical aspects of breastfeeding, and of socio-cultural factors affecting initiation and cessation. Research has emphasised the biological nature of infant feeding and motherhood, and a body of knowledge has developed promoting breastfeeding globally as the optimum method of infant feeding (Kramer and Kakuma, 2012; WHO, 2002; WHO, 2011). Breastfeeding has been suggested to represent both a medical gold standard for infant feeding and a moral gold standard for mothering (Knaak, 2005, p197). Numerous international, national and local public health policies cite recommendations and targets in an effort to increase breastfeeding prevalence. NICE (2006) postnatal care guidance

recommends that the UNICEF UK Baby Friendly Initiative should be the minimum standard for the NHS. Despite this increasing evidence base, and encouraging rises in breastfeeding initiation year on year, there remains a dramatic drop-off during the early postnatal period. Of significance, in Lincolnshire, the prevalence of breastfeeding at 6-8 weeks shows a decreasing trend year on year (2008-2012) (EMPHO, 2012).

Ontologically, it has been questioned whether breastfeeding is regarded as a biological or socio-cultural activity. Opposing the wealth of empirical biomedical research purporting breastfeeding as a purely biological concept, a passive and natural act, social scientists have recently debated the issue of how far the social construction and social control of breastfeeding are dominated by medical models, women's roles or cultural background. Researchers have noted that breastfeeding is not confined solely to the physical process of producing milk within a lactating organ (the breast) and the mechanical transfer of that milk to the infant (Bartlett, 2000). Women approach breastfeeding within a specific social, cultural, political and historical context (Bartlett, 2005); lactation '*is culturally practised as breastfeeding...is gendered*' (Bartlett, 2000, p179).

In order to research what is ontologically assumed to be a socio-cultural activity, it is necessary to explore the meanings, values and beliefs held by those who experience directly the phenomena under investigation. This leads into an interpretive approach and a qualitative method that can deepen understanding of the phenomenon of breastfeeding. The methodological orientation of this study was that of hermeneutic or interpretive phenomenology, an approach that seeks to understand human

experience from the perspective of individuals' experiences of life events, and the meanings these events have for them.

This chapter is organised into two main sections. The first section begins by outlining the research question addressed, then explores theoretical perspectives and competing paradigms in contemporary research, along with a justification for the chosen interpretive phenomenological approach. Drawing principally on the perspective of Martin Heidegger, phenomenology provided an appropriate theoretical and practical framework for understanding the phenomenon of breastfeeding that incorporated the context and individual experiences of each participant. The second section details the setting in which the study was undertaken. Details of the research methods employed and the process of interpretive data analysis are presented. Finally, the approaches used to enhance rigour as suggested by Sandelowski (1986) are described.

3.2 RESEARCH QUESTION

I began this study with the aim of exploring women's experiences of breastfeeding. This aim emerged as a result of reflecting on my professional experiences in midwifery and health visiting practice, my personal experience as a breastfeeding mother, and understanding of the literature on breastfeeding. The research study has been organised around one research question:

How is the phenomenon of breastfeeding manifest in the lives of women in one East Midlands city?

3.3 CHOOSING THE METHODOLOGY

The research design process begins with philosophical assumptions that the researcher makes in deciding which approach to take. In addition, researchers bring their own epistemological and ontological perspectives, which inform the conduct of the study. There are two dominant paradigms – positivism and interpretivism. Quantitative research is generally associated with the philosophical tradition of positivism. Qualitative research is most commonly associated with interpretivism (Avis, 2003). In the positivist paradigm, the fundamental concern as Rolfe (2000, p66) and Avis (2003) explain is with producing generalisable knowledge using scientific methods. The emphasis is on ordered, measurement-oriented and reducible methods of inquiry to ensure that the research findings are decontextualised and depersonalised. All influences of people, places and situations are thus disassociated from the findings. The positivist philosophy embraces a concept of truth which can be verified through scientific examination and observation of external reality (Avis, 2003). From the interpretivist viewpoint, knowledge is established through the meanings ascribed to the phenomena studied; researchers interact with the participants, and knowledge is context and time dependent (Rolfe, 2000). Furthermore, Rolfe (2000) and Sandelowski (2000, p334) describe a hierarchy of evidence in research, whereby randomised controlled trials represent the gold standard of the spectrum, and interpretive methods are located at the other end of the hierarchy. However, Rolfe (2000) goes on to question the basis for this hierarchy of evidence which values generalisable knowledge and the scientific method, stating that it offers one method for constructing knowledge, and he cautions that

In throwing out the bathwater of the authoritarian scientific Method, we are forced into also throwing out the baby of the possibility of any method offering a more authoritative account of truth than any other.

(Rolfe, 2000, p68).

The choice of approach is dependent upon the context of the study and the nature of the research question asked. One major criticism of the positivist approach is that it does not provide the means by which to examine human beings, who are subject to many influences on behaviour, feelings, perceptions and attitudes, in an in-depth way. Thus an underpinning positivist philosophy would yield limited data that would provide a superficial view of the phenomenon of breastfeeding. In recognition that the purpose of this research study was to explore the phenomenon of breastfeeding, the world of the women experiencing breastfeeding and what is meaningful or relevant to them, an interpretivist paradigm was deemed appropriate. The three approaches of grounded theory, ethnography and phenomenology were considered. The aim of grounded theory is to generate or discover a theory. It was devised by Glaser and Strauss in 1967 as an alternative to the deductive approach of positivism (Glaser and Strauss, 1967). It is often used for exploring areas where there has been little exploration of contextual factors that affect individuals' lives, or where a new perspective might be desirable. Comparative analysis of data is used to develop a theory which predicts, interprets and explains behaviour (Glaser and Strauss, 1967). The aim of this research study was to understand the meaning of women's experiences of breastfeeding in context, rather than providing a framework

that predicts, interprets and explains behaviour. Ethnography has its roots in cultural anthropology. Such an approach relies on collecting naturally occurring data in the field to study how individuals are influenced by the culture in which they live (Parahoo, 2006). Whilst acknowledging the impact of cultural influences on breastfeeding, to utilise an ethnographic approach would limit the possibilities for exploring other aspects and influences on the phenomena of breastfeeding. Further, given the time and financial constraints as a part time doctorate student, this approach would have been inappropriate. Phenomenology is the study of phenomena (Smythe, 2011). Phenomenological research seeks to understand lived experience or the life world (van Manen, 1997). The choice of a phenomenological approach seemed most appropriate to the context of the study and the nature of the research question asked.

3.4 OVERVIEW OF PHENOMENOLOGY

Phenomenology is both a research method and a philosophy to study experience (Smythe, 2011). As a research tradition, it was developed as an alternative to the empirically based positivist paradigm (Spiegelberg, 1982). Spiegelberg (1982) described the historical roots of phenomenology as a movement rather than a discrete period of time. This reflects the dynamic and evolving nature of our understanding and practice of this philosophical perspective. There are a number of schools of phenomenology, or as Spiegelberg (1982) notes, as many phenomenological philosophies as there are phenomenologists. Whilst these all share some commonalities, they also have distinct features. Edmund Husserl (1859-1938), a German mathematician, is often credited

as the father of phenomenology (Koch, 1996). However, Husserl's descriptive phenomenology emerged from a project initiated by his mentor, Franz Brentano (Glendinning, 2007). Husserl sought for principles, foundations, upon which science could be built. He urged researchers to search for reality, '*the things themselves*' (Husserl, 1970, p252). For Husserl (1970), the aim of phenomenology is the rigorous and unbiased study of things as they appear in order to arrive at an essential understanding of human consciousness and experience. In order to hold subjective perspectives and theoretical constructs in abeyance and facilitate the essence of the phenomenon to emerge, Husserl (1970) devised phenomenological reduction and argued that the 'lifeworld' (*Lebenswelt*) is understood as what individuals experience pre-reflectively '*before we have applied ways of understanding or explaining it. It is experience as it is before we have thought about it*' (Crotty, 1998, p95), without interpretation. Husserl advocated 'putting aside' any assumptions about the subject matter ('bracketing'), allowing the essence of the phenomenon to emerge itself. This approach places the researcher as a detached, unemotional observer (Paley, 1997). The ability to suspend beliefs and assumptions gained from previous knowledge and lifeworld (personal experience of breastfeeding, and professional experience of supporting women to breastfeed), by 'bracketing' them seems incompatible with midwifery research that values a woman-centred approach to enhance practice.

Martin Heidegger (1889-1976), a student of Husserl, developed phenomenology into an interpretive or hermeneutic philosophy. According to Spiegelberg (1982), Heidegger's phenomenological approach was designed to interpret the ontological meanings of such human conditions

as being-in-the-world, anxiety and care '*with results as startling as they were original*' (p7). Heidegger takes as his starting point what he terms '*Dasein*', the '*being there*' (Heidegger, 1962, p27) of human existence. This being there means that we are thrown into the world (*geworfen*) that we live in. We are always already there (*da*), involved in daily activities, but the term *Dasein* also signifies that we have a relation to our own existence, in asking what it means to be there at all (as opposed to not existing). According to Heidegger, when we study our relationship to the world, we should not view the world as a collection of objects outside of consciousness, we should instead study the way we are *in* the world, giving it meaning through our actions. Heidegger critiqued Husserl's approach to phenomenology, and explicitly rejected Husserl's notion of 'bracketing'. Table 3, comparing and contrasting Husserlian and Heideggerian approaches to phenomenology, can be seen on page 67 of this thesis. Heidegger's interpretive phenomenological approach focuses on illuminating details within experience that may be taken for granted in our lives, with the goal of creating meaning and a sense of understanding. Smythe (2011) suggests that this approach is particularly relevant to studies aiming to develop understanding of phenomena that are taken for granted, covered over or silenced amidst theoretical/scientific debate.

Table 3: Comparing and contrasting Husserlian and Heideggerian approaches to phenomenology

Husserlian phenomenology	Heideggerian phenomenology
Transcendental phenomenology	Philosophical hermeneutics, interpretive phenomenology
Epistemological	Existential-ontological
Epistemological questions of knowing	Questions of experiencing and understanding
How do we know what we know?	What does it mean to be a person?
Cartesian duality mind-body split	<i>Dasein</i>
A mechanistic view of the person	Person as self-interpreting being
Mind-body person lives in a world of objects	Person exists as 'being' in and of the world
Ahistorical	Historicality
Unit of analysis is the meaning giving subject	Unit of analysis is the transaction between the situation and the person
What is shared is the essence of the conscious mind	What is shared is culture, history, practice, language
Starts with a reflection of mental states	We are already in the world in our pre-reflective selves
Meaning is unsullied by the interpreter's own normative goals or view of the world	Interpreters participate in making data
Participants' meanings can be reconstituted in interpretive work by insisting that data speak for themselves	Within the fore-structure of understanding interpretation can only make explicit what is already understood
Claim that adequate techniques and procedures guarantee validity of interpretation	Establish own criteria for trustworthiness of research
Bracketing defends the validity of objectivity of the interpretation against self-interest	The hermeneutic circle (background, co-constitution, pre-understanding)

(Koch, 1995, p832)

3.5 HEIDEGGERIAN INTERPRETIVE PHENOMENOLOGY

The meaning of phenomenological description as a method lies in interpretation

(Heidegger, 1962, p61).

Heidegger commenced his work by presenting an ontological analysis of Dasein as a way of interpreting the meaning of being and the structures of existence (Healy, 2011). At the beginning of *Being and Time* (Heidegger, 1962), Heidegger emphasises that the fundamental nature of Dasein, the Being of human beings, is its existence, and to each of us our existence is our own. Dasein is distinctive in that its Being is an issue for it, and its life, unlike the life of animals such as the frog sunning itself, or objects such as a chair, is something with which it must concern itself. This approach assumes we make sense of lived experience according to its personal significance for us.

Heidegger (1962) suggests that Dasein can only be understood through our everyday relation to and understanding of the world. Heidegger defines three modes of experiencing the world. When we are coping skilfully with the world, we experience entities around us as '*ready-to-hand*' (Heidegger, 1962, p102). Heidegger gives the example of a hammer encountered ready-to-hand, as a piece of equipment, when it is being simply used to drive nails into wood. Our engagement with entities ready-to-hand does not involve explicit awareness of their properties (Blattner, 2006). Sometimes, though, our skilful coping is temporarily disturbed. When this

happens, we encounter entities as '*un-ready-to-hand*' (Heidegger, 1962, p103). When we encounter entities as un-ready-to-hand, we experience them as disturbing our coping with the world, and we must focus closely on our activity (Blattner, 2006). Heidegger's third way of experiencing the world is as '*presence-at-hand*' (Heidegger, 1962, p104). The hammer is encountered as presence-at-hand when we stop hammering and consider the hammer's shape or weight. The hammer is no longer a useful piece of equipment but merely an object with various properties.

Heidegger (1962, p40) also incorporates the temporal character of Dasein: the past, present and future. At any point Dasein is dealing with the past, from where it has come from. Heidegger refers to this as 'thrownness'. Simultaneously Dasein is always ahead of itself, projecting itself into the future which Heidegger refers to as 'projection' or 'possibility'. Heidegger uses the word 'fallenness' to encompass what is happening in the present. Thus to understand a person's behaviour or expressions, the person should be studied in context. Koch (1995) outlined Heidegger's emphasis on the historicity of understanding as one's background or situatedness in the world. Historicity, a person's history or background, includes what a culture gives a person from birth and is handed down, and presents a way of understanding the world (Koch, 1995). Koch (1996) further emphasises Heidegger's assertion that nothing can be encountered without reference to the person's background understanding, that we are self-interpreting beings (p176). Through this understanding, one determines what is 'real', yet Heidegger also believed that one's background cannot be made completely explicit. Whereas Husserl (1970) advocated researchers shed their prior personal knowledge, Heidegger (1962) contended that it is

impossible to undertake this, and that it is the researcher's knowledge base that leads to specific ideas about understudied areas.

The concept of a hermeneutic circle was adopted by Heidegger as a way to understand our Being-in-the-World. Heidegger (1962, p191) suggested that interpretation is founded upon *fore-having*, *fore-sight* and *fore-conception*: something we have in advance, the background context, something we see in advance (perspective) and something we grasp in advance. Heidegger went as far as to claim that nothing can be encountered without reference to a person's background understanding. Koch (1995) described this as an indissoluble unity between a person and the world. Meaning is found as we are constructed by the world while at the same time we are constructing this world from our own background and experiences. Meaning is therefore a co-construction between study participants and researchers.

For Heidegger, understanding is no longer conceived of as a way of knowing but as a mode of being, as a fundamental characteristic of our 'being' in the world.

(Koch, 1995, p831).

The hermeneutic circle therefore is concerned with an interpretation of Being; an interpretation that, on the one hand, is guided by certain historically embedded ways of thinking, and, on the other hand, is continuously open to revision, enhancement and replacement. Heidegger describes this further as

if we see this circle as a vicious one and look out for ways of avoiding it, even if we just 'sense' it as an inevitable imperfection, then the act of understanding has been misunderstood from the ground up.

(Heidegger, 1962, p194).

Heideggerian interpretive phenomenology holds that the notion of a single reality is not possible. Heidegger (1962) argues that each person will perceive the same phenomenon in a different way, each bringing to bear their lived experience, specific understandings and historical background. Every mother can experience breastfeeding differently, thus creating multiple realities. This can be said to be true for each participant but also for each member of the research team (including my research supervisors). However, within the uniqueness of each person's experience there is understanding that resonates with others.

It is the interrogation of the phenomenon in its appearing which allows us to recognise, to verbalise, maybe for the first time, the taken-for-granted which always lay right there, unrecognised...as part of the phenomenon

(Ashworth, 2003, p146).

Adopting a Heideggerian interpretive phenomenology to explore the phenomenon of breastfeeding will provide an in-depth woman-centred understanding of breastfeeding. This approach acknowledges the individual and unique nature of being-in-the-world and the interconnectedness of

experiences from the context within which those experiences occur. I chose interpretive phenomenology, following the philosophical ideas of Heidegger as I felt that this philosophy was the best approach to meet the aims of the research: it addressed the need to explore and make sense of women's experiences, but included using my own professional and personal experience and knowledge of infant feeding.

There have been a number of debates surrounding the interpretation of phenomenology by nursing researchers (Crotty, 1998; Paley, 1997; Paley, 1998; Lawler, 1998). Crotty (1998) asserts that nursing researchers have misinterpreted European phenomenological philosophy. Paley (1998) argues that nursing researchers have misread Husserl and Heidegger. Horrocks (2000) suggests that this misinterpretation in the nursing literature may be due to nurse academics relying upon secondary interpretations of philosophical arguments

Nursing theory needs to look at the primary sources of a philosopher and not depend upon secondary sources

(p243).

Horrocks (2000) contends that Benner's concept of intuition (as part of her development of the novice to expert model of skills acquisition in nursing) is weakened because of the '*distorted view*' (p241) of Heideggerian philosophy interpreted from Dreyfus (1991). Lawler (1998) suggested that

Nurses are sometimes required to invent methodology and design in order to manage unexpected events or issues on which the textbooks are silent or unhelpful

(p105).

Yet it must be remembered that Heidegger's seminal texts are philosophical texts rather than research method textbooks. This view would seem to echo Crotty's (1998) and Paley's (1997, 1998) criticisms. My initial choice of interpretive phenomenology as a research methodology was made with limited knowledge and understanding of the philosophical frameworks; indeed, I was swayed by the plethora of published articles exploring experiences in health care that cited phenomenology as their chosen methodology, but as identified by Crotty (1998) and Paley (1997, 1998), often misguidedly. Studying translated philosophical texts is not a brief or simple undertaking. As someone who has genuinely attempted to read and digest Heidegger's (1962) *Being and Time*, in addition to a number of other philosophy texts, I can attest to feeling that the more I read and wrestled with the language and complex ideas, the more confused and the more I felt as though I knew even less than when I started this process.

Lawler (1998, p107) counters Crotty's (1998) criticisms of nursing's appropriation of phenomenology, suggesting that as different cultures shape phenomenology, different disciplines will have a characteristic way in which they appropriate and operationalise philosophies to investigate their particular concerns. Caelli (2000) suggests that changes to methodology may have arisen because the "*approach is being used for research rather than the solitary philosophical reflection of Husserl and*

Heidegger' (p373). In a recent critique questioning the importance of methodological theory to nursing research, Porter (2008) argues that an in-depth exploration of the philosophical variants of phenomenology contribute little to the quality of the research undertaken. He suggests that nurse researchers use phenomenology's basic assumptions, without any significant compromise to the integrity of the research (p268). However, I would contest this viewpoint and encourage researchers to explore the philosophical tenets upon which research enquiries have been designed and the scientific basis for their findings. Heidegger does not provide details in relation to the precise steps indicated to undertake an interpretive phenomenological research study. However, several researchers offer their interpretation of how such philosophy is translated into methodology and methods (Greatrex-White, 2007; Mackey, 2005; Smythe, 2011; van Manen, 1997).

The following section describes the research setting, and presents details of the research methods employed, the process of interpretive data analysis and the approaches used to enhance rigour.

3.6 METHODS

3.6.1 The Research Setting

Lincolnshire is the fourth largest county in England, covering approximately 6000 square kilometres (Lincolnshire Research Observatory, 2012).

Population change in Lincolnshire has been more rapid than in most other areas of the United Kingdom in recent years. Immigrant workers from Poland, Lithuania, Latvia and other European Union new member states comprise a large component of the seasonal agricultural workforce (Lincolnshire Research Observatory, 2012). The birth rate has also been rising significantly, with a rate rise of 53.3% between 2002-2011 across the County (Lincolnshire Research Observatory, 2012). Indications are that international migrants are also starting families here. In 2010, over 17% of births in Lincoln and over 35% of births in Boston were to women born outside the United Kingdom (ONS, 2012). Unlike urban, multicultural areas such as London, Birmingham, Leicester and Bradford with established ethnic minority communities, Lincolnshire has until very recently been one of the least ethnically diverse counties in England.

According to government data sources and utilising the DEFRA 2009 classification system, Lincolnshire is classified as 'mostly rural', defined as where between 50% and 80% of the population live in rural settlements or market towns. Deprivation in Lincolnshire is diverse and complex, and there are health inequalities within Lincolnshire by gender, level of deprivation and ethnicity. Whilst the health of people in Lincolnshire is generally better than the England average, the health of people in Lincoln is generally worse (EMPHO, 2012). In Lincolnshire, levels of road injuries

and death are worse than the England average, and life expectancy for women is lower than the England average (EMPHO, 2012).

Despite evidence of the benefits of breastfeeding to the health of mothers and infants, rates of exclusive breastfeeding have shown only marginal increases (HSCIC, 2012). As stated in section 2.2.2, in Lincolnshire the prevalence of breastfeeding at 6-8 weeks shows a decreasing trend year on year (EMPHO, 2012). As part of efforts to improve public health, two infant feeding co-ordinators were appointed to community posts in Lincolnshire in April 2008. A Breastfeeding Support Worker Programme was funded from April 2010-March 2011. This team provided a seamless service for families in a designated post coded area, as a pilot project for both the acute hospital setting and the community of Lincolnshire. BreastStart, the voluntary breastfeeding peer support programme, is also operational across Lincolnshire. The local acute hospitals Trust were awarded Stage 2 accreditation in April 2011, and Lincolnshire Community Health Service NHS Trust achieved Stage 1 accreditation of the UNICEF BFI in September 2011.

3.6.2 Participants

In phenomenological research the researcher wishes to sample the expressions of lived experiences relevant to the phenomenon of interest. A non-probability purposive sampling strategy was therefore designed to select participants who had experienced the phenomenon investigated in order to gain a depth and richness of data. Potential participants were primiparous or multiparous women aged 16 years or over, who had given birth to a healthy full term (greater than 37 completed weeks gestation)

infant, initiated breastfeeding at the birth of their youngest baby and breastfed for at least 11 days. The minimum 11 days exclusive breastfeeding experience was chosen for three reasons. Firstly, I wished to recruit via health visitors rather than midwives, as I hoped this would negate a Hawthorne effect whereby midwifery practice may have altered due to the interest being shown as part of a research study. Secondly, the research aim was to explore the phenomenon of breastfeeding, and whilst 11 days may seem a short period of time in which breastfeeding could be considered established, I did need to make some decision about a minimum experience for the study. Dykes (2005) had already conducted an ethnographic study of the early postnatal experience in the postnatal ward. Her participants had breastfed between 2 and 5 days at the time of data collection; Dykes et al (2003) study of the experience of adolescents recruited participants with breastfeeding experiences from 4 days to 5 months, and one participant in Gatrell's (2007) study had only breastfed for 3 days. I did not wish to duplicate studies of the very early postnatal experience when women would be trying to establish breastfeeding and their milk supply. Thirdly, I wished to explore the phenomenon of breastfeeding from the perspective of women who had initiated breastfeeding, to explore their breastfeeding journey from starting to breastfeed to between three and six months in an effort to help to identify more effective and appropriate support mechanisms for breastfeeding. I was also mindful that if I had collected the data during the early postnatal period, women may have been reluctant to criticise aspects of care and more likely to express satisfaction. Details on recruitment and time of data collection are in section 3.8.

3.6.3 Sample Size

Determining sample size for this study was no mean feat: whereas quantitative research utilises power calculations to determine the number and kind of sample size required, sample size in qualitative research and specifically interpretive phenomenology receives relatively little direction in the published literature. Van Manen (1997), Ashworth (1997) and Greatrex-White (2007) postulate that sample numbers are unimportant in a phenomenological study. In this context, sampling is not about size but quality (Todres, 2005). The aim is not to count how many people have had a particular experience or to make comparisons between different groups of people, rather the aim is to understand a phenomenon more deeply through adequate exposure to the qualities of the phenomena that are given by the living of the phenomenon (Todres, 2005). Sandelowski (1995) suggests that sample size for a phenomenological study

will likely require 10 to 50 descriptions of a target experience in order to discern its necessary and sufficient constituents

(p182)

but summarises that the decision is ultimately 'a matter of judgement and experience' (p 183). She suggests the following principle

An adequate sample size...is one that permits... the deep, case-oriented analysis... and that results in...a new and richly textured understanding of experience.

(p183).

Baker and Edwards' (2012) review paper highlights the paucity of explicit guidance and agreement on determination of sample size in qualitative research. Some authors make specific suggestions regarding sample sizes in relation to phenomenological studies, for example Creswell (2007, p120) suggests between 5 and 25. Initially, when writing the study protocol and application for NHS research ethics approval, I had been required to stipulate a figure for the number of participants. My estimate for NHS research ethics of 30 was based on limits of time and resources rather than anything more substantial. Sandelowski (1995) explores the dilemma between a sample size that is too small to support claims of having achieved either informational redundancy or theoretical saturation, or too large to permit deep, case-oriented analysis that results in a richly textured understanding of experience. Bryman (2012) states that many experts agree that saturation is ideal, although a challenging approach in combining sampling, data collection and data analysis, not withstanding project proposals requiring researchers to state a number at the project's inception (such as for NHS research ethics). However, the concept of data / thematic saturation is a contested notion in relation to phenomenological research where the emphasis is on each individual woman's experience. Some researchers consider that the point of saturation can never be reached as human life is unique and there will always be more to discover (Savin-Baden and Howell Major, 2013). Theoretical saturation developed in the approach of grounded theory (Glaser and Strauss, 1967). Data / thematic saturation is a variation for other qualitative methods. This concept is generally taken to mean that data should be collected until nothing new is generated (Green and Thorogood, 2004). This is a different understanding to the concept of theoretical saturation used by grounded theorists. In grounded theory, the notion of theoretical saturation refers to all categories being fully accounted for, the variability between them are

explained and the relationships between them are tested and validated and thus a new theory can emerge (Green and Thorogood, 2004).

I initially identified a sample size of 20 to 30, and continued data collection until I believed I had reached a point of data / thematic saturation, when no more emergent patterns were appearing in the data. This corresponded to the point at which Sandelowski (1995) suggests a clearer understanding of the experience would not be found through further discussion with participants. Smythe (2011) concurs with this notion, suggesting that one reaches a state of knowing that one more interview will be too many. She describes it as a river *'Already the insights are emerging like a river of thought. To keep pouring in more runs the risk of overflowing the banks which somehow holds the thoughts in a coherent whole'* (p41). I considered that I had reached data / thematic saturation around participant 18 (Rebecca), but I continued with the next four women as data collection had already been arranged and those women had all been recruited through snowballing (Parahoo, 2006) and had therefore expressed a particular interest in participating in my study.

3.6.4 Data collection

The literature indicates contention around the various data collection techniques available. In phenomenology, the data collection method aims to elicit phenomena, that is what the participants experience regarding the phenomenon under study (breastfeeding) (Greatrex-White, 2007; Greatrex-White, 2008). The use of observational methods were briefly considered in an effort to overcome what Holloway and Jefferson (2000, p3) describe as *'people's...contradictory relationship to knowing and telling about*

themselves'. However, a key limitation of observational methods discussed by Green and Thorogood (2004) is that it is extremely time-consuming to both gain access, conduct the fieldwork and any consolidation that might be required. Furthermore, given my professional background as a midwife and health visitor, my presence over a period of time in a woman's home may have influenced the outcome.

Van Manen (1997) describes 12 different aspects of investigating lived experience, the majority of which have their basis in the act of writing. Use of diaries or interviews was then considered. Both of these forms of data collection would need to be unstructured, leaving the participants free to express the sense they made of the world. I felt that to ask the women to complete an unstructured diary for the first three to six months of their baby's life was a huge expectation. I considered video and audio diaries as an alternative to handwritten, but without any study funding support, this was not a viable option. Completing a diary can be resource intensive but with limited return for the participants. Additionally, there is evidence that populations with low levels of education are less able to provide accurate records in these ways than if they are asked direct questions (Bruijnzeels et al, 1998). Exploring the potential for utilising diaries as data collection method, a number of studies reported poor recruitment, poor completion rates and high drop-out rates, particularly in those studies that collected data for more than 7-10 days (for example Barnett et al, 2008). Both of my research study supervisors had experience using diaries as data collection tools in previous research projects (Fraser et al, 2013; Greatrex-White, 2008). Whilst both reported excellent completion rates, they also cautioned regarding their experiences of obtaining an overwhelming volume of data, and the subsequent impact on data analysis. Taking all this into

consideration, I discounted this method of data collection.

The chosen data collection method was therefore in-depth interviews. Interviews in this context were neither structured (with a pre-organised plan or set of questions), nor completely unstructured whereby there would have been no clear sense of why the interview was being undertaken or focus of exploration. Face-to-face interviews were chosen to facilitate inclusion of subtle non verbal aspects of communication. In-depth interviews allow the participants to decide for themselves the direction of their stories, enabling their voices to be heard *'unmitigated and unadorned by the researcher'* (Finch, 2004, p63). Not only is this approach intended to, as far as possible, redress any power imbalance between researcher and participant, but also it is commonly acknowledged that if participants are to 'open up' within the research setting, they need to be as comfortable as possible with the situation and not to feel constrained by formal questioning. Consequently, an interview that seems more like a conversation is seen as likely to produce more fruitful results. Researchers utilising a Heideggerian approach assert that participants' experience and interpretation of being-in-the-world are enmeshed in a background of linguistic and cultural traditions that can only be understood and interpreted by another being-in-the-world, as Crotty (1998) acknowledges, the researcher. Interviews in Heideggerian phenomenological research are thus a co-creation between researcher and participant.

The literature suggests that only one initial question needs to be asked (Smythe, 2011). In this study, the initial opening question was *'Can you tell me about your experience of feeding your baby'*. Occasionally,

participants required initial prompt questions such as *'When did you decide that you were going to breast feed your baby when he / she was born?'* and *'Is / was breast feeding how you imagined it would be?'* This enabled their fore conceptions to be explored in light of subsequent experience in an ongoing hermeneutic circle of interpretation. A number of prompts in order to keep the interview open included *'can you tell me more about that?'* *'how did that make you feel?'* *'what were your initial thoughts on that?'* *'how do you feel about that?'* Participants were asked to illustrate their points with specific examples or incidents in order to explore their experience in detail.

Data was collected between July 2009 and January 2010. Only one interview with each participant was undertaken. Phenomenological research is by its nature temporal. Given Heidegger's belief in the relevancy of context, to undertake a subsequent interview to explore the experience again may have altered the meaning or interpretation ascribed to that experience. What was felt at that time may well be interpreted or felt differently in another time. Smythe (2011, p41) and Ashworth (2003) concur that one interview is enough. Additionally, visiting more than once to interview may have had some influence upon the woman's infant feeding behaviour.

I collected the data when the participants' youngest baby was between three and six months of age. This was so that I would gain data from women with a range of infant feeding experiences – women who were exclusively breastfeeding, women who had initiated breastfeeding and then changed to formula, and any combination in between. The inclusion criteria were to have initiated breastfeeding at birth and continued at least until the Health Visitor's

first visit around 11-14 days. Setting the upper limit for data collection at six months provided an opportunity to gain perspectives from women who may have breastfed exclusively for six months – the current WHO recommendation (WHO and UNICEF, 2003). Setting the lower limit at three months was a pragmatic decision chosen to reflect a critical point at which early weaning onto solid food may occur (Bolling et al, 2007).

3.7 ETHICAL CONSIDERATIONS AND APPROVAL

All research involving human participants must be subject to ethical scrutiny and approval. The four ethical principles of respect for autonomy, beneficence, non-maleficence and justice (Beauchamp and Childress, 2009) underpin this study.

Respect for autonomy refers to the requirement to ensure that research participants are entirely free to make a choice about their participation in a research study. Participants were provided with information on the research study (appendices 4 and 5) and provided with time for both reflection and further discussion. If they were interested in discussing the study further / participating, they would then contact me directly using contact details on the participant information sheet. As I collected the data between 3 and 6 months postnatally, to ascertain that nothing untoward had occurred in between identification of suitable participants and data collection, so as not to cause unnecessary distress, I checked with the woman's Health Visitor before contacting to arrange data collection in

instances where there was a length of time between the initial contact from the participant and the data collection date. Written consent was in line with NHS REC guidelines (appendix 6). There were no inducements to take part in the study. It was important to emphasise that participation in the research study was voluntary, that they were free to withdraw at any time and without giving reason, that there were no right or wrong answers and that the study explored their experience of infant feeding. If participants became distressed during the interviews, they had the opportunity to terminate the interview / their part in the research study.

The principle of beneficence means doing good in the sense that the research has scientific value, and that the benefits of the research justify the resources or risk of harm to the research participants. The findings from this study have been presented at the Nutrition and Nurture in Infancy and Childhood conference (as detailed on page iv of this thesis), and further plans to discuss and disseminate the findings to mothers and health care professionals within the local maternity unit and postnatal groups have been arranged.

The principle of non-maleficence means that researchers have an obligation not to inflict harm on their study participants. I was mindful that the openness and intimacy of such in-depth interviews on their experiences of infant feeding may have led participants to disclose information they may later have regretted sharing (as identified by Kvale and Brinkmann, 2009). Confidentiality and data protection principles were strictly observed, for example the identities of participants were protected by the use of a code that ensures that all data (digital recordings and

interview transcripts) are anonymised. The code was allocated once informed consent had been given by the participant. All participants were given pseudonyms to ensure anonymity. In allocating pseudonyms, I gave each mother a name corresponding to the alphabet to denote the order in which they were interviewed (the first being Abigail, the second Belinda). I also allocated each infant a pseudonym starting with the same letter of the alphabet as the mother's pseudonym, which helped me to link the mother and child when analysing the texts. Before data was stored, any identifying data was removed. The digital recorder was stored in a locked cupboard during the period of data collection, and following completion of the study will be cleared of data. Identifiable data has been stored for between 12 months to 3 years to allow for participants to request a summary of the study findings to be sent to them. Documents containing anonymised participant data for the study are stored in a locked cupboard at the University where they will be available for scrutiny with permission from ethical review bodies for seven years before being destroyed (using a shredder). All data has been viewed solely by the researcher and supervisors, and not exchanged electronically.

The principle of justice means treating people in an equal and fair manner. It has been noted in the research literature that participants are influenced by the perceived role and status of the interviewer (Holloway and Wheeler, 2010). It is important to consider also that mothers, particularly first-time mothers, have been reported to feel that their infant feeding decisions are ideologically judged as 'good' or 'bad', particularly by midwifery staff (Battersby, 2000). Although I had verbally introduced myself as a doctorate student and nursing academic, some participants commented on my status as a qualified health visitor, which I assume they gleaned from my list of

qualifications on the participant information sheet. In such circumstances, I countered that I was employed as an academic and had never practised clinically in that geographical area.

As I was collecting data from participants during a particularly vulnerable time period in their lives, if I encountered any participant that I was concerned might have been suffering from postnatal depression, I offered them referral to their Health Visitor or General Practitioner.

Ethics approval to conduct this study was granted by the University Of Lincoln School Of Health and Social Care Research Ethics Committee (appendices 7 and 8), the Leicestershire, Northamptonshire and Rutland 2 Research Ethics Committee, and the Lincolnshire Primary Care Trust Research and Development department. Gaining NHS Research Ethics Committee approval using the relatively newly introduced Integrated Research Application System took a matter of weeks. However, negotiating research governance approval with the local Primary Care Trust was a protracted six month process necessitating numerous meetings with the Head of Research at the Trust and with the Human Resources department at the University.

3.8 ACCESS AND RECRUITMENT

In order to gain access to potential participants, meetings between the researcher and the Health Visitor manager and Health Visiting teams within the locality were organised to discuss the proposed study. I asked all Health Visitors in the central city (Lincoln) locality to identify women at their first visit (11-14 days postnatally) who had initiated breastfeeding at birth and were currently breastfeeding, and ask them if they might be interested in participating in this study. A participant information sheet outlining the purpose of the study and what it involved was provided (appendices 4 and 5). If prospective participants were interested in discussing the study further / participating, they would then contact me directly using contact details on the participant information sheet. In addition to accessing potential participants via the local health visitors, some participants were recruited via snowball sampling (Parahoo, 2006), whereby participants who had been recruited via their health visitor asked if they could pass on my contact details and the participant information sheet to women they knew who fulfilled the inclusion criteria. I was also invited to discuss my study with a local breastfeeding support group and a postnatal support group, and this also generated interest to participate from a number of women who filled the inclusion criteria. By speaking briefly about the study at these groups, I was able to emphasise that I was interested in hearing about their breastfeeding experiences, and that the inclusion criteria was to have initiated breastfeeding at birth and continued at least until the Health Visitor's first visit around 11-14 days. I felt that it was important to gain a broad spectrum of 'everyday' participants, not necessarily solely those who had initiated and were still exclusively

breastfeeding, nor solely those who had initiated breastfeeding but ceased within the first few weeks.

3.9 DATA GATHERING

A mutually convenient date, time and venue was agreed via telephone or email for the interview to take place. Whilst I had offered a choice of venues to undertake the interview, all the women requested that the interviews took place in their own homes. I ensured that I arrived in good time. All of the women offered me refreshments prior to starting the interview – I accepted each time as I felt this demonstrated my willingness to not just undertake the interview and leave immediately. It also afforded me an opportunity to set up the space for the interview in terms of ensuring the tape recorder was in a convenient place and the seating arrangements were comfortable, but also to try to put the women at ease by gently getting to know them in 'small talk', taking an interest in them, their families, their home circumstances. This assisted in developing some degree of trust and conversational rapport. I also made sure that they understood about the study they were participating in, answered any questions they may have had, prior to signing the consent forms and turning on the tape recorder.

Only the initial question was asked, although occasional prompts were made such as *'can you tell me more about that?' how did that make you feel?'* Participants were asked to illustrate their points with specific

examples or incidents in order to explore their experience in detail.

Paraphrasing and reflecting back were also used to ensure clarity. I did not gather detailed demographic details or histories of the women's labour and delivery. This was a purposeful decision to avoid being sidetracked into long discussions, to remain focused on the phenomenon of breastfeeding and their experience of breastfeeding.

A theme within my reflective diaries was the tension I felt between researcher and health care professional. When the women described their experiences of care received, or lack of care received; when they cried as they did occasionally recollecting events or the ways in which they were spoken to that they perceived to be judgemental or callous, I was tempted to offer advice, or pass opinion. Sometimes they asked me about my personal experience of breastfeeding, or asked me for advice on weaning or sleep management. I was mindful that I was acting as a researcher, and not as a midwife or health visitor. I avoided offering advice. However, in keeping with Heideggerian tenets that interviews are a two-way conversation, I did respond to distress or anxiety with words of reassurance, or offered them referral to their Health Visitor or General Practitioner.

3.10 PROCESS OF QUALITATIVE DATA ANALYSIS

My study worked with the phenomena from 22 in-depth interviews with 22 women of their experiences of breastfeeding. I approached analysis of the

interview data having read Koch (1996), van Manen (1997), Ashworth (2003), Greatrex-White (2008) and Smith et al (2009). Data was managed by hand without the aid of a specialist computer programme as I wished to become intimately acquainted with the data. However, I did use NVivo version 7 to manage and sort the data.

The first step in analysing the data was to transcribe the interviews. I undertook this myself due to a number of factors – firstly in order to familiarise myself with the data through repeated listenings, but secondly because I was not successful in gaining any additional research funding for a professional transcriber. This was a time consuming task, not only to type the audible data, but once completed each interview was listened to again to check it against the transcription to correct any mistakes or omissions.

The second step was to code the data (figurative view of analysis process, figure 2 on page 96). The text for the analysis constituted the interview transcripts and field notes from the interviews. Transcripts were between 13 and 53 pages in length, totalling 559 pages of text, a total of 140,275 typed words. I read and re read each interview transcript alongside my field notes and reflexive research diary from the day that interview had been conducted. It was important to also gain a sense of each woman's experience as a whole, rather than as fragments of typed phrases. I also revisited the audio recording of the whole interview on further occasions. Such listening enabled me to get a sense of the 'whole'.

At this first stage descriptive comments or phrases were noted (*'initial noting'*, Smith et al, 2009, p83) as well as interpretive conceptual comments. Having familiarised myself with the data through a process of listening, transcribing, reading and re-reading, I scrutinised the interview transcripts line by line to identify some initial codes from the data. These initial notes (or codes) identify a feature of the data that appears interesting to the analyst, and refer to *'the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon'* (Boyatzis, 1998, p63). See table 4 for an example of codes applied to a short segment of data:

Data extract	Coded for
And like I said I felt probably more pressured but I wasn't doing it for me. And the next one, I had when I was 26 I think. I tried breastfeeding with him, um, I breastfed him for about four months, but I went [Belinda, p2]	Pressurised to breastfeed. Did not breastfeed for herself, not her choice. Tried breastfeeding, attempt made with second child.

Table 4: Data extract, with codes applied

Initial reading developed into deep engagement on subsequent readings. As advised by my supervisor (Greatrex-White, 2007; 2008), I interrogated each account with my research question 'how is this breastfeeding?', 'what are the data saying about the experience of breastfeeding?' and 'what else might be going on?' This helped to move deeper into the data, deeper understanding and deeper into the experience. As I began to understand the phenomenon, I began to ask more informed questions of the text. I was guided throughout this process by my forestructures of understanding

of the topic. An interpretive summary of each interview was written (example in appendix 9). This is what Smith and Osbourn (2003, p51) termed the *double hermeneutic*, emphasising the two interpretations involved in this process: in the first the participant makes sense of a phenomenon by explaining and interpreting their own experience. The second is the researcher explaining and interpreting the meaning of the participant's account (Smith et al, 2009). The circularity of the process (questioning, uncovering meaning and further questioning) involved in understanding and interpreting a phenomenon is termed the hermeneutic circle (Smith et al, 2009).

On first reading of the transcripts all the things I had expected to find explicated by women who have breastfed were described: acknowledgement of breastfeeding as the optimum method of infant feeding; conflicting information from professionals; difficulties with position and attachment in the early postnatal period. But in addition to these, the women were discussing things I had not anticipated, or things that might, at first read, have been attributed to earlier descriptions in published literature of the experience of breastfeeding, but with descriptions of their own experiences that were powerful and profound, culturally and context-bound.

The next stage involved a move away from the transcript to working with the 'initial notes' to develop emergent themes. This was a difficult stage involving reduction in volume whilst maintaining depth and complexity. In accordance with Heideggerian principles, it was also important to maintain openness towards the meanings within the data. One of the quandaries I

encountered whilst analysing the data was that of my changing forestructures and not wishing to cloud the deep engagement and analysis of subsequent interviews by forging ahead to search for clarification and affirmation of the themes identified in the previous interview. In acknowledgement of this, I immersed myself in each woman's account of her breastfeeding experience; I made every attempt to engage with each woman's account and their reflection as a testimony in its own right. Dialogue with my two supervisors was crucial at this stage.

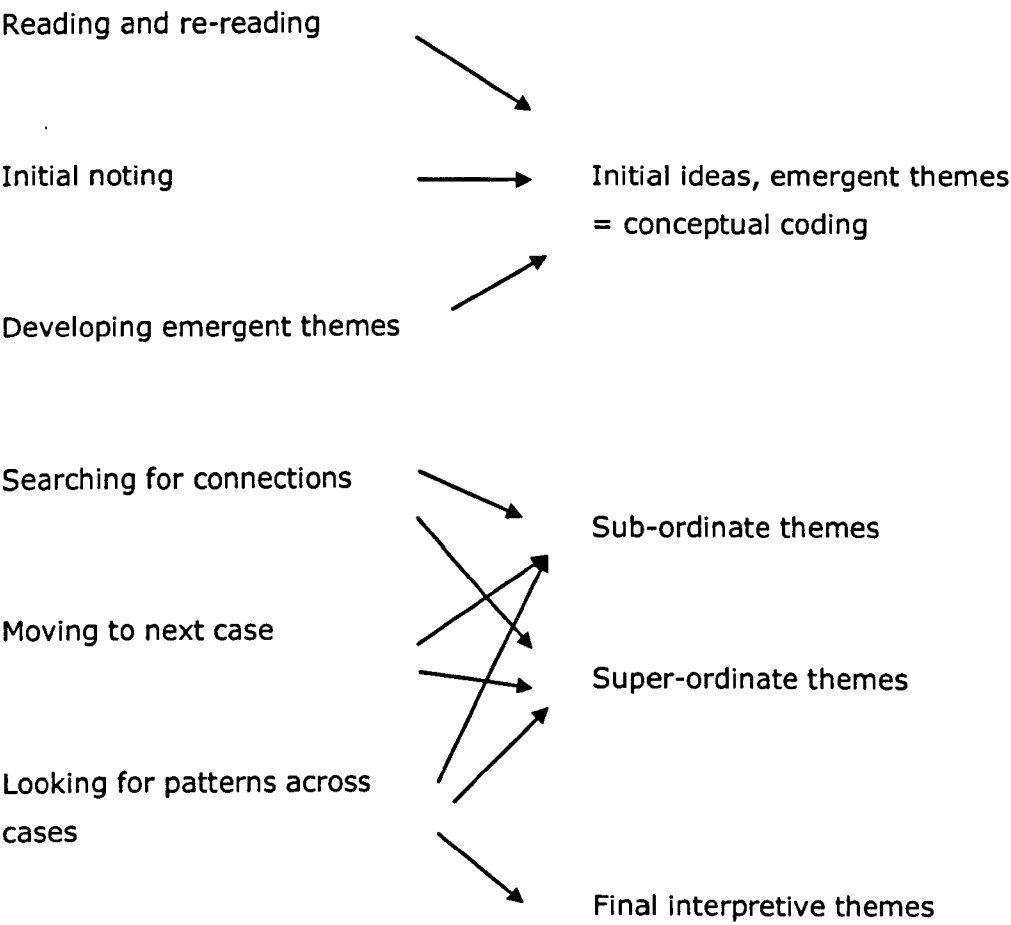
The next stage was to look for connections across the emergent themes and identify superordinate themes. Similar themes were clustered together (putting like with like) and given a new name describing them all – a superordinate theme. These stages were repeated for each interview, field notes and reflexive diary entries. However, in order to remain as close to the raw data as possible and focus my analysis within a deep engagement with that data, I decided only to analyse one interview in a day, and to return to the raw data for that interview on a subsequent occasion and re-interrogate it. This was to ensure the research question was central to the analysis of the data, and in recognition that I needed to be mindful of what the data was saying, not what I was anticipating it to say.

Finally a cross-case analysis was conducted which involved looking for commonalities and differences, and renaming themes as a deeper understanding of the data developed (Smith et al, 2009). The search for constitutive patterns involved reading the whole interview texts to gain an overall perception of the stories and depicting the link between the relational themes that existed in all the interviews.

It was also important that the final account should be plausible. Because of the interpretive stance, I am not claiming to have produced a definitive analysis. The data presented supports the claims I have made, but it is unlikely that an independent researcher would identify exactly the same themes in exactly the same way, based on their personal contexts and experiences. However, by providing this audit trail, it is possible to scrutinise the development of the analysis from transcript to final presentation of themes (see figure 2).

Figure 2: Figurative view of analysis process

Steps to analysis



3.11 RIGOUR

The need for qualitative criteria of rigour is discussed widely in the literature (Annells, 1999; Maggs-Rapport, 2001; Sandelowski and Barroso, 2002a; Sandelowski and Barroso, 2002b). Koch (1996) suggests that '*each inquiry determine its own criteria for rigour*' (p 174) and argues for

expansion of the concept of rigour in qualitative research...there may be little consensus around the idea of rigour, legitimacy of knowledge claims are dependent upon demonstrating that the research study is trustworthy and believable

(p178).

Criteria of rigour are necessary to ensure accountable, systematic and quality research methodology. Sandelowski and Barroso (2002a) suggest that the quality of the study is revealed in the write-up and is therefore subject to the wise judgement and keen insight of the reader. For this study, the generic qualitative criteria of rigour suggested by Sandelowski (1986) of credibility, fittingness, auditability and confirmability were used:

Credibility may be established using member checks, whereby data, findings, interpretations and conclusions are shown to research participants for them to judge the accuracy of the account (Porter, 2007). However, member checking can be problematic. Sandelowski (2000) suggests that participants may regret what they said in earlier interviews, or feel

compelled to agree with the researcher. In phenomenological research, the data are considered credible if others can recognise the experience as one they have had (Crotty, 1998; Paley, 2002), and are considered meaningful to practitioners (Cutcliffe and McKenna, 1999). Van Manen (1997, p27) termed this the '*phenomenological nod*'. Van Manen (1997) also suggests that the co-construction in the interview itself is a member check. Indeed, given that the interviewer clarifies what was meant by a statement at that moment, rather than some time later, this could be deemed a more valid member check.

Fittingness refers to the extent to which the study's findings fit into other contexts outside the study setting (Sandelowski, 1986). Through a detailed discussion of the findings, and the use of quotes from participants, readers can understand the data collected and draw their own conclusions about relevance to their own practice. Sandelowski (1986) referred to the process of auditability as a decision trail so that the research process could be verified by the reader (see figure 2 on page 96 for exposition of data analysis process). Confirmability is achieved when credibility, auditability and fittingness can be demonstrated.

Reference to existing literature before data collection and following analysis ensured consistency with existing research findings (Holloway and Wheeler, 2010). Analytical notes were added immediately after the interviews and during transcription. Rigour was also enhanced through discussions with my doctorate supervisors who read all interview transcripts and agreed the emerging themes.

The findings from this study have been presented at the Nutrition and Nurture in Infancy and Childhood conference (as detailed on page iv of this thesis), and at a postgraduate research showcase held at the University of Nottingham. These were opportunities to disseminate findings. They also provided opportunities for scrutiny of the project from audience members who included postgraduate researchers, and academics interesting in infant feeding. Further plans to discuss and disseminate the findings to mothers and health care professionals within the local maternity unit and postnatal groups, and publications in peer-reviewed journals have been planned.

Koch and Harrington (1998), Murphy and Dingwall (2003) and Greatrex-White (2007; 2008) suggest that incorporating a reflexive account of research processes can enhance rigour. It is suggested that the interpreter can never escape his or her own background and stance that creates the possibility of an interpretive foreground, the forestructure of understanding. Researcher subjectivity is inevitably implicated in research; it could be suggested that it is precisely the realisation of the intersubjective interconnectedness between researcher and researched that characterises phenomenology. Koch (1995) recommends the researcher keep a research diary in which they outline their role in the research process whilst conducting interpretive phenomenological studies. I started a diary when I first registered for the doctorate, and for the first few months it was little more than jotting ideas, questions for supervision, lists of tasks to undertake and journal articles to search for. As the study progressed so did the research diary, in which I made notes from meetings not only from supervision but also from discussions with doctorate student peers and research colleagues such as the head of research in the local

primary care trust. Diary entries were also made immediately after each interview had been completed whilst the experience was central and fresh, as an *aide-memoire* when recalling the atmosphere of the interviews, initial thoughts and any problems encountered along the way. Gradually the research diary took shape and as my writing developed I began to use it for more reflective thoughts on the progress of the doctorate and the developing themes and the implications for clinical practice and education/training.

3.12 SUMMARY

To uncover what meaning women give to their experiences of breastfeeding, Heideggerian interpretive phenomenology was chosen as the research methodology. This research study was based upon developing a phenomenological investigation to explore mothers' experiences of breastfeeding. This approach was chosen seeking to explore and understand mothers' views of breastfeeding their infants, as it is proposed that in order to understand the inherent complexities of successfully promoting and supporting breastfeeding, a woman's breastfeeding experience must be examined within her specific context. This understanding depends upon concepts such as knowledge and how we understand mental processes such as thinking and feeling. These epistemological enquiries and ontological enquiries are core components of philosophy.

A purposive sample of primiparous and multiparous women who had all breastfed their youngest baby for at least 11 days were provided with information about the study by their health visitor at the primary birth visit. If these women chose to participate in the study, an in-depth face-to-face interview was undertaken when their youngest baby was aged between three and six months. Rigour has been enhanced through credibility, fittingness, auditability and confirmability.

The next chapter provides an introduction to the findings and interpretation of the study findings in relation to the literature.

CHAPTER 4

INTRODUCTION TO THE FINDINGS CHAPTERS

4.1 INTRODUCTION

Before the study findings are presented, the original research question is reiterated. The research question asks 'How is the phenomenon of breastfeeding manifest in the lives of women in one East Midlands city?' The findings are presented in three themes, each presented in separate chapters. However, there are occasions when the themes interrelate. The next three chapters explicate women's experiences of breastfeeding. This is the description of the experience developed from an understanding of the perspective of women who have breastfed obtained through phenomenological enquiry. These chapters show, through phenomenological interpretation, that the women found breastfeeding to be a 'reality shock'; they maintained 'illusions of compliance', and their experience of breastfeeding was influenced by 'tensions'. The findings are presented in separate chapters under theme headings, and discussed and interpreted with reference to the literature and related theory.

The emerging themes appear to be negative views of the experience of breastfeeding. Enjoyment of breastfeeding was not a common description in the women's accounts. Some of the women did recount positive aspects of their experience of breastfeeding. These participants also talked about

the things that could have made the experience of breastfeeding even better. I wondered if this reflected that participants were aware of my professional background from the invitation to participate and the participant information sheet. Taking into account that the impetus for undertaking this study was to explore the phenomenon of breastfeeding to try to uncover why so many women initiate breastfeeding but then discontinue, the sections highlight specific aspects that could improve care. Although most of the quotes used illustrate how the themes were arrived at, where relevant I have included some of the more positive/contradictory views.

In the following chapters I have attempted to provide a detailed and nuanced account of these three themes within the data, rather than providing a rich thematic description of the entire data set. This is because some of the themes that were initially identified have already been discussed in the extant literature, such as an expectation of failure and awareness of the benefits of breastfeeding. The three themes were not necessarily the most prevalent themes across the data set, but together they captured an important element of the way in which women discussed their experiences of breastfeeding. Under each of the thematic chapter headings are a cluster of sub themes. These chapters offer my interpretations of the findings that have emerged from women's experiences of breastfeeding. These interpretations are inevitably influenced by me being a woman, mother, midwife, academic, breast feeder. I have been diligent in attempting to be open to the women's voices rather than my own.

4.2 DESCRIPTION OF PARTICIPANTS

I collected limited demographic data on the participants as I wished to remain focused on the phenomenon of breastfeeding and to avoid being diverted into long discussions on the woman's labour and birthing experience. The personal details of participants were tabulated for ease of reference (see tables 5 and 6). Analysis of personal details revealed variation in the sample of women included in the study. The participants in this study were aged between 16 and 37 years at the time of the interview, primiparous and multiparous women (ranging from parity 1 to parity 5); 21 of the participants described themselves as white, British, and one as Asian; 21 were either married or cohabitating, and were in a long term heterosexual relationship with the youngest baby's father, except for one participant, Tanya, who was a single mother living with her parents.

Participant	Maternal age (years)	Parity	Occupation	Marital Status
Amita	27	1	Unemployed	Married
Belinda	31	5	Health Care Assistant	Married
Charlotte	24	3	Housewife	Cohabiting
Denise	19	1	Unemployed	Cohabiting
Elizabeth	34	1	Shop assistant	Married
Fiona	34	3	Housewife	Married
Georgina	29	1	Physiotherapist	Married
Heidi	24	1	Insurance Advisor	Married
Isla	26	1	Unemployed	Cohabiting
Jenny	30	1	Administrator	Married
Kelly	29	2	Adult Nurse	Married
Lindsay	36	1	Graphic Design	Married
Michelle	23	1	Student	Married
Nicola	25	2	Credit analyst	Cohabiting
Octavia	24	2	Sales Advisor	Cohabiting
Pauline	37	1	Unemployed	Married
Queenie	36	1	Social Worker	Married
Rebecca	34	2	Health Care Assistant	Cohabiting
Sharon	26	2	Youth Worker	Married
Tanya	16	1	Student	Single
Ulrica	28	2	Office Worker	Married
Veronica	26	1	Marketing Manager	Cohabiting

Table 5: Demographic details of participants

Characteristics		Number of participants
Parity	Multiparous	9
	Primiparous	13
Age	<20 years of age	2
	20-29 years	12
	30-39 years	8
Marital status	Single	1
	Cohabiting	7
	Married	14

Table 6: Demographic summary of participants

All the participants had given birth in the local hospital. All the youngest babies were aged between three and six months at the time of the interview. None of the women had returned to employment at the time of data collection except for Michelle who had recommenced her undergraduate study at University when her baby was four weeks of age. All of the women participating in this study began by breastfeeding their youngest infants and breastfed for at least two weeks; 12 were exclusively breastfeeding at the time of the interview. More specific details on the participants’ breastfeeding duration at the time of interview are in Table 7.

Participant	Youngest baby's age at interview (months)	Duration any bf (months)	Duration exclusive bf (months)
Amita	6	6	6
Belinda	6	6	6
Charlotte	3	3	3
Denise	3	3	0
Elizabeth	6	6	5.5
Fiona	6	6	6
Georgina	6	5.5	4
Heidi	6	1.25	0.75
Isla	6	1	0.25
Jenny	4	4	3
Kelly	3	3	3
Lindsay	4	4	4
Michelle	3	3	3
Nicola	3	1	0.75
Octavia	4	4	2.5
Pauline	3	3	3
Queenie	6	1	0.5
Rebecca	3	3	3
Sharon	3	3	3
Tanya	3	3	3
Ulrica	4	4	4
Veronica	3	3	0.75

Table 7: Breastfeeding duration of participants

4.3 THEMES AND SUB-THEMES

The completed thematic map can be seen in Figure 3, showing the relationship between the different levels of themes (main overarching themes and sub-themes within). Each theme is linked back to the overall research question (how is the phenomenon of breastfeeding manifest in the lives of women in one East Midlands city?), but each is distinct. In the subsequent discussion of the three themes, the spider diagrams that were used to represent the relevant codes are included, with difference in shading relating to the sub-themes within each theme.

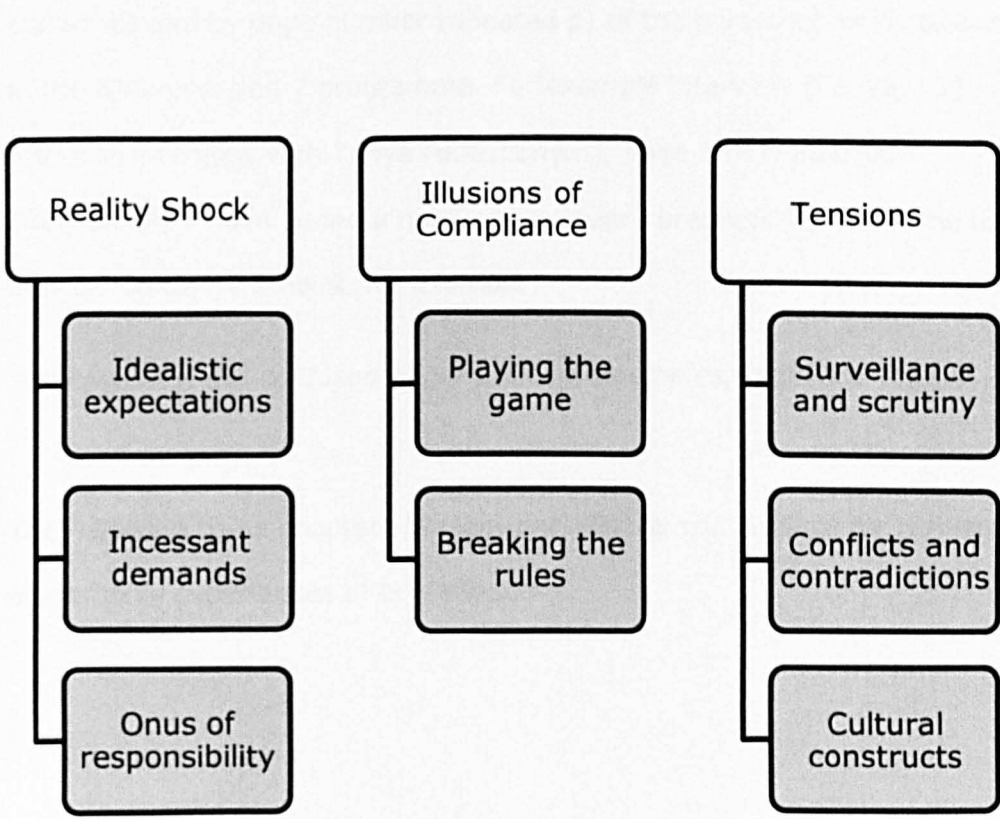


Figure 3: Thematic map showing main themes and sub-themes

4.4 CONVENTIONS ADOPTED TO PRESENT THE FINDINGS

The findings from the analysis of the data are described in the following description in the next three chapters with use of anonymised verbatim extracts (shown in italics and indented where more than a couple of words) taken from the interview transcripts. Quotes from the data are presented in italics, single line spaced. To protect the identity of the participants, all names are pseudonyms which are denoted within square brackets. All quotations were referenced by the pseudonym given to the interview transcript and by page number (denoted p) of the transcript as it appeared in the NVivo version 7 programme. For example interview [Tanya, p3] refers to interview with Tanya (pseudonym), page 3 of transcript. Occasionally I have added a note within square brackets [] within the text in order to clarify a point, for example

'they [babies] get confused about sucking on nipples, teats and things'

The following three chapters present and discuss the findings for the study of women's experiences of breastfeeding.

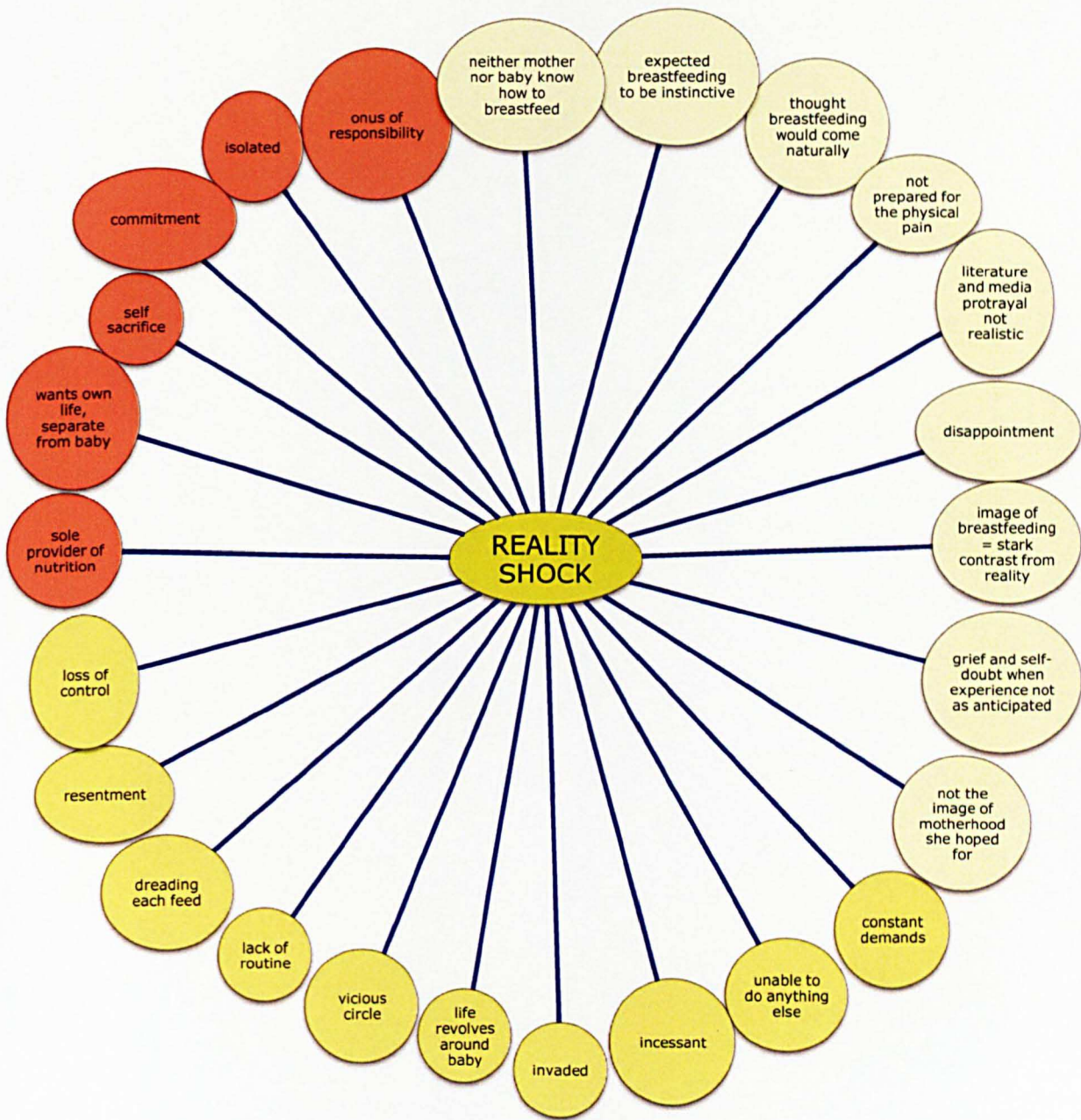
CHAPTER 5

REALITY SHOCK

5.1 INTRODUCTION

In this chapter, the findings from the study in relation to one main theme - reality shock - are presented and discussed. In this theme women talk of how they were ill-prepared for the realities of breastfeeding, and for most of them the shock of this experience was overwhelming. They expressed their sense of a loss of control and frustrations in their encounters with this 'natural' bodily function. They found the demands and onus of responsibility for breastfeeding their newborn baby to be incessant. They expressed disappointment in themselves when their idealistic expectations and experience did not match.

Figure 4: Thematic spider diagram showing main 'reality shock' theme and sub-themes



'Reality shock' sub themes	Colours of sub-theme codes
Idealistic expectations	
Incessant demands	
Onus of responsibility	

5.2 SUB THEME ONE: IDEALISED EXPECTATIONS

There seemed to be a chasm between the women's expectations of breastfeeding and the reality, which was characterised by descriptions that were raw and interspersed with feelings of loss. Most of the women knew very little about breastfeeding prior to becoming pregnant, other than knowing it was best for baby. Thirteen of the women in this study described how their expectations of breastfeeding antenatally were different from their actual experiences. 'Shock' was commonly used by the women to express their reaction to breastfeeding. They seemed ill-prepared for the realities of breastfeeding, and for most of these women the shock of this experience was overwhelming. During pregnancy, their awareness of breastfeeding grew, but their expectations and anticipation of breastfeeding centred around breastfeeding being 'natural', which they translated as innate ability. Women like Denise, aged nineteen with her first baby, had perceived breastfeeding to be a natural process and was frustrated that neither mother nor baby had an innate ability to breastfeed:

I was getting a little bit...frustrated with myself. I was like, I ought to be able to do this. It just wasn't coming as naturally as I thought it would....The latching on, the positioning, I suppose I thought you'd know how to do that but I've needed help [Denise, p10]

Jenny, who had worked as an administrator in a human resources department of a large company prior to taking maternity leave with her first baby, also expected breastfeeding to be intuitive, that she would instinctively know how to breastfeed when her baby was born:

I also thought that breastfeeding would come naturally to the baby. I didn't think like she would have to learn it as well as me. I thought if I just swung my boob near her mouth she would know what to do and latch on herself [Jenny, p6]

Lindsay's best friend and sister had both breastfed their infants, and told Lindsay it was "*fantastic, it's so easy*" which led her to perceive that she would have a natural ability to breastfeed:

I was foolishly under the impression that breastfeeding was just a given [Lindsay, p1]

Pauline, also a first time mother, anticipated both herself and her newborn infant to have an intrinsic ability to breastfeed:

...you expect it to be a really natural thing, that she'll know what she's doing and somehow I will know what I'm doing, and neither of us do really [Pauline, p20]

The portrayal of breastfeeding in media such as television programmes (factual and fiction) and in the professional literature provided to women antenatally was described by two of the women as unrealistic. Fiona, mother to three children, commented how breastfeeding was portrayed in the media '*It's [breastfeeding] not what people expect though. You don't see it much on the telly, not really. When you do see it, it's sort of extremes really*' [p15], discussing a recent television documentary she had seen on extended breastfeeding. Kelly [p29] discussed how she felt the professional literature provided to women was '*confusing...nobody says this is your guide, don't worry. You don't have to do it like this*'.

Inadequate preparation for breastfeeding culminated in some of the women not feeling prepared for the discomfort of feeding in the early postnatal period, and for the time commitment required for each and every breastfeed. Amita described the physical pain she experienced, particularly in her attempts to latch her newborn baby on her breast in the early postnatal period. It was so painful that she reiterated a number of times in her interview that determination was needed to continue with breastfeeding. Pauline evocatively described the physical pain she experienced as '*crunching*' [p5]. Breastfeeding was also found to be a tiring and exhausting process:

I'm too tired and it's too much effort to go out [Jenny, p28]

I think also I'm much more tired and I think the breastfeeding is making me tired. It does seem to be taking a bit out, a bit out of me. And that's something that I thought, how can it make me so tired, you're sat on the sofa relaxing, so called relaxing, with your feet up, with a drink, your husband's nicely bringing you drinks every now and again when he's at home at the weekends, how can it be so tiring, what's so tiring about it [Lindsay, p21]

The women's accounts of their experiences of breastfeeding were often imbued with complex emotions such as guilt and self-doubt, particularly for those women whose breastfeeding experience did not match up to their expectations of themselves. Prior to breastfeeding, Queenie had perceived that breastfeeding was an easy aspect of motherhood. As a qualified social worker, she had had professional experience supporting families with their infants. However, once she engaged in the act of breastfeeding, she discovered that her assumptions had led to unrealistic expectations. Like Denise, Queenie too expressed disappointment in herself:

I was meant to be able to do this [Queenie, p9]

The difference between Queenie's expectation of breastfeeding as a 'bonding time' and the reality was stark:

I didn't even feel as if it was a bonding time with him, I just felt, because it was painful and urm he wasn't being satisfied by it, I just, it was, I suppose I was anxious which didn't help, so I never quite felt that it was our time to connect with each other. It was a nightmare....It was a nightmare to be honest [Queenie, p4].

Comments from the women indicated that many struggled with the loss of life as it used to be, and felt that they had lost control over their own lives. Difficulties reconciling the rose-tinted image of the mother settled in an armchair and breastfeeding her infant who settled to sleep between each feed, with their fragile and fraught struggle with painful and frequent attempts to breastfeed a fractious baby was a major source of distress. Heidi described herself as an independent woman with a successful career. Despite this, she still spoke of the image of the good mother with the perfect baby who fed and slept between feeds, waking with a smile and able to enjoy going to the park in the pram with his parents. She described how this image had a hold over her, how she strove to mirror the image, noting how disappointed she was with herself that she did not achieve this. In her interview she broke down in tears at describing this disappointment

I was trying my damned hardest, I just couldn't do it, it's just hard [cries]...I just couldn't do anything at all. I couldn't get out...Just trying to get on with the simple things like the washing and stuff...it was just a nightmare [Heidi, p9]

For Heidi, breastfeeding was intertwined with her image of motherhood. Having introduced formula feeds at three weeks, and stopping

breastfeeding completely just after a month, she felt that she had failed to attain this ideal and, when interviewed when her son was just over six months of age, she found recounting her breastfeeding experience provoked memories that were painful and distressing

It isn't how motherhood is supposed to be [Heidi, p21]

Enjoyment of breastfeeding was not a common narrative for the women in this study. However, for some of the women the reality of their breastfeeding experience exceeded their expectations. For these women, breastfeeding was easier and better than they had expected, not as difficult and they continued to breastfeed longer than they had planned initially as a consequence. They expressed their experience in terms of convenience:

It's so easy, I can go anything, just go with the baby and you just get up and go, so long as you are there. I was out seeing one of my friends, oh my God, I see her getting ready to go out, sterilising, packing this, packing that, oh my, what you have to do, now I just go with him, so long as I am with him [Amita, p13]

I've actually been able to go out and not have to take all the equipment... I've just had to be there, not loading up the bag. So it saves a hell of a lot. The cleaning, the bottles you don't have all of that [Belinda, p6]

Any time any where any place [Elizabeth, p16]

...it is just a whole lot easier, it is always there, it's always the right temperature, you can just give them it [Octavia, p10]

particularly at night-time:

... I just pick him out of the Moses basket, give him a feed and pop him back but if I was bottle feeding I'd have to come downstairs, make up a feed, warm it up, it would be such a rigmarole instead [Rebecca, p10]

...neither of us particularly wants to come downstairs in the middle of the night and start messing around with kettles. Which I don't know whether that's a good reason to stick with breastfeeding but [laughs]. It seems a lot easier to keep her in a dark room to get her back to sleep than messing around at two in the morning making bottles just seems like a bit of a hassle...I think one of the reasons I'm sticking with breastfeeding is I don't have to leave her bedroom...it's a lot easier for all of us...on the whole I find it a lot easier, urm, not messing around with the steriliser the whole time and it doesn't matter if we're somewhere and we haven't got a bottle [Veronica, p25]

5.3 SUB THEME TWO: INCESSANT DEMANDS

The women's descriptions of breastfeeding, particularly in the early days, were imbued with a sense of constantly needing to be present, an inability for personal freedom. For some women, this led to frustration that they were in constant demand, a feeling that they could not escape or hand over to someone else, even temporarily. These feelings were expressed by both primiparous mothers and multiparous mothers. The incessant demands of breastfeeding an infant in the early postnatal period led to some of the women beginning to dread each feed:

I thought oh no another breastfeed, got to do it [Pauline, p9]

oh gosh she wants feeding again [Nicola, p1]

and overwhelming feelings of disappointment in themselves and personal failure when they subsequently stopped breastfeeding. For Queenie, who was a first time mother, the whole process of breastfeeding was 'a *nightmare*'. Her baby was small for dates, so she was advised by the hospital midwives to put him to her breast and then supplement with a prescribed amount of milk every few hours. This entailed an '*incessant*' regime of either expressing or putting the baby to the breast, which she continued on discharge home on the second postnatal day. She was in tears for much of the first few weeks with little sleep. If she did not manage to express enough breast milk, the baby was given formula top-up. As a consequence, she began to view feeding as a vicious circle:

I was dreading each feed, it was so painful the sharp sensation that you get when they latch, and the sorer my nipples got and every time he did it, it was, oh excruciating, to the point where it was bringing me to tears, to the point that I'm not going to use that breast any more, but I know you have to use both, and so I tried to limit the time on each one, to limit the time on the sore one, but it was [sharp intake of breath] each time [Queenie, p19].

Queenie's narrative describes her struggle to breastfeed, despite severe discomfort, sore nipples and a relentless regime of either expressing or trying to position and attach her newborn son. Despite persevering for four weeks, the occasional formula milk top-up resulted in the baby sleeping between feeds, which reinforced to her that he was '*happier*' on formula milk. By four weeks he was exclusively formula feeding. Queenie's experience led her to feel resentment towards the health care professionals for advocating and promoting breastfeeding to the exclusivity of alternatives, but at the same time not being as supportive and helpful as she had envisaged in order for her to establish breastfeeding. She confided that she also felt guilty after she decided to wean her son completely onto formula feeds. However, she was not the only woman to anticipate each

breastfeed with 'dread', nor was this feeling confined to first time mothers, these next quotes are both taken from multiparous mothers:

I just, he wouldn't latch on, I was getting stressed, he was getting stressed and we ended in this cycle of me dreading him being hungry [Charlotte, p1]

I was getting to the point where I was actually feeling sick, where I was thinking 'oh here we go again'.....It would get to a night time and I was absolutely dreading it....I just can't cope with no sleep because I was literally not getting any sleep in between his feeds... I was dreading him crying and needing a feed. When you're breastfeeding you're sort of on your own [Nicola, p6]

The women expected difficulties with breastfeeding such as bleeding and cracked nipples, reinforced by the creams and samples in their Bounty packs and the plethora of creams, ointments and aids for breastfeeding (such as nipple shields) in shops. However, they did not expect that the 'difficulty' that other mothers talked about to be the incessant demand, the fact that they could not do anything but feed some days, and they could neither share nor delegate what became viewed as a task, or to some, an inconvenience. The unrelenting demands of a breastfed infant led to the women feeling as if their own lives were on hold, and that they were hemmed in, which women like Amita described as 'My life is him now. I am not important'. Veronica, who was still breastfeeding at the time of her interview, adapted to this lack of routine and pattern to breastfeeds:

I have stopped trying to plan my life completely round when she's going to want her next feed because it seems a bit random anyway [p37].

but for others, their feelings were quite different:

I won't deny for a minute that there hasn't been times when I've thought oh please, please just let me have half an hour, please let me have just half an hour, please you know, and then I've felt guilty afterwards, because I've thought it's not his fault, he just wants feeding, you know that's, you know, that's just being rotten [Lindsay, p30]

It just seemed really constant. I just couldn't do anything at all. I couldn't get out... I'm the one with the boobs stuck to the front of my chest.... I barely had time to go to the loo, let alone have a shower or do the washing or pop to the shops or do anything you normally would. Which was a really bizarre experience, going from being really independent, driving, full time job, doing what I want when I want...stuck indoors for three and a half weeks. I'm going to go mad in these four walls [Heidi, p13]

I don't want to be tied down to feeding her all the time [Kelly, p23]

It was me, me, me all the time [Queenie, p10]

Ulrica, mother of two, talked of her infant feeding decisions being pragmatic rather than what she described as a 'romantic' notion of breastfeeding. Her eldest child had self-weaned at eighteen months from breastfeeding. She was interviewed when her youngest child was four months of age, exclusively breastfeeding. For her, being constantly in demand, physically and emotionally, resulted in some confusion over bodily boundaries:

it was getting me down, and I said oh you just kinda feel, urm, invaded sometimes [Ulrica, p4]

5.4 SUB THEME THREE: ONUS OF RESPONSIBILITY

The reality of the women as solely responsible for feeding the infant was stark, particularly on discharge from hospital. Some of the women described feeling scared when they were home from the hospital, as they felt they had no one to ask for help, no one on the end of the buzzer, and that they were not prepared, competent or confident with positioning and attachment when they were discharged from the hospital. For some, the responsibility of breastfeeding in terms of being the sole provider of nutrition for their baby was overwhelming and suffocating. This was noted in the descriptions given by both first-time and experienced mothers in the study. Belinda, mother of five, described herself as '*a fridge...A larder*' [p8]. Pauline described the responsibility she felt as sole provider of nutrition for her baby as

a massive responsibility, you know, to make sure the baby's healthy, because the only source of nutrition they're getting is for you, and I think you do feel that responsibility. 'Cos it's, you know, the only way that they're kinda surviving is through the breast milk [p26]

Ulrica contemplated not having sole responsibility for infant feeding '*it would be nice for it not to be me all the time*' [p15]. Throughout Nicola's interview she described how she felt the burden of responsibility as a mother was overwhelming with her first child

I was 24 and I was like oh my God, just left with this baby and obviously you're tired you know, like oh I've got this massive responsibility, you know...what have I done, do you know what I mean, can I cope with this responsibility? And there was times when I thought you take him. I can't do it. And I was like that, I can't do it, I can't cope, he doesn't like me, I'm doing something

wrong, he was constantly crying, you know I'm not, there was something, he doesn't like me, he hates me [Nicola, p25]

She expressed her breast milk so that she could both involve her partner in infant feeding, but also to relieve herself of the sole responsibility for feeding with her second child. Octavia found that the introduction of an occasional formula feed enabled her to have a degree of control in her life and a degree of separation from the onus of responsibility to breastfeed:

it's kinda given me back my life a bit now [Octavia, p30]

Veronica found the onus of responsibility for breastfeeding in the night time physically and mentally 'exhausting' [p4]. As a first time mother, she described feeling isolated in the first few weeks after her daughter was born, ascribing this isolation to 'Nobody could sort of help' [p21]. She had no family or friends with experience of breastfeeding, and so turned to her health visitor for advice and support. However, her health visitor had not completed the breastfeeding management course and despite promising that she would request one of her colleagues to contact Veronica, no one did. Veronica had attended antenatal classes, but she was the first one to birth from her group, and did not have the confidence to attend a postnatal group until her daughter was eight weeks old as she felt self conscious about feeding in public.

Some of the women in this study (such as Denise) who were initially judgmental about women who did not breastfeed, discussed how their prenatal and antenatal judgemental attitude had changed having experienced breastfeeding for themselves. They talked about the

realisation of how much hard work and self sacrifice was needed for breastfeeding, and the dedication and commitment needed to continue, and was not necessarily solely a choice regarding infant feeding method in the same vein as choosing between tea and coffee:

Now I've had the chance to look back, it's every woman's choice to do it how its best for them. You don't know all their circumstances [Denise, p26]

Interestingly, three participants (Rebecca, Sharon and Ulrica) strove to outperform other mothers - to breastfeed longer than their contemporaries:

she [first child, aged eighteen months] stopped of her own accord. I was a bit miffed because my friend had gone on until her daughter was two and I thought right we'll beat that [laughs] [Ulrica, p3].

However, whilst vocalising their goals to breastfeed until their children self-weaned, they also expressed feeling an onus of responsibility and incessant demands, as illustrated later in Ulrica's interview '*it would be nice for it not to be me all the time*' [p15].

5.5 DISCUSSION

It is clear from the data that women's experiences of breastfeeding were generally not what they had anticipated. Most participants did not find breastfeeding a natural process, instead it came as a shock. Breastfeeding was challenging. Most of the women found the phenomenon of breastfeeding to be something that concerned them greatly, that they had to concentrate on. The findings suggest that preparation for breastfeeding is inadequate and misleading. In this study, a more realistic idea of breastfeeding may have helped the women to prepare more effectively for their breastfeeding role. This concurs with previous research that identified a mismatch between women's expectations and the reality of breastfeeding (Hoddinott et al, 2012; Redshaw and Henderson, 2012). Whilst the extant literature has already highlighted inadequate preparation for breastfeeding, the extent to which this had a negative impact on the breastfeeding experiences of women in this study was a surprise.

It has been argued that the United Kingdom has a predominately bottle-feeding culture (Cattaneo et al, 2005; Bolling et al, 2007), with women rarely, if ever, witnessing breastfeeding prior to having their own baby. This results in very limited understanding of breastfeeding, gleaned predominately from health care professionals in the antenatal period. This preparation centres around the health benefits of breastfeeding, with postnatal support centring on teaching and support with positioning and attachment. All the women in this study intended to breastfeed, were aware of health benefits of breastfeeding, and all initiated breastfeeding following the baby's birth. Professional and popular messages that promote

breastfeeding have been very successful. We have prepared women to initiate breastfeeding but not to sustain breastfeeding. Steps three and five of the Baby Friendly Initiative *Ten Steps to Successful Breastfeeding* (WHO, 1998) stipulate that maternity services should 'Inform all pregnant women about the benefits and management of breastfeeding' and 'Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants'. However, findings from this study indicate a gap surrounding a lack of understanding and preparation for common problems, and a lack of awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant feeding behaviours such as crying, wakeful states and cluster feeding, on the specific method of infant feeding. The end result was a vicious circle of dreading feeds. There was a drive in the women's descriptions to establish routine and predictable feeding and sleep patterns. The frequent demands made by their breastfed baby were unexpected and worrying. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply. This concurs with a systematic review of evidence surrounding the concept of insufficient milk syndrome (Gatti, 2008). In social cultures where friends and family have not breastfed themselves, this can lead women to question their abilities to breastfeed further, particularly when infant feeding behaviours are held in direct comparison with the behaviours of formula fed infants. There is disagreement in the literature about how best to prepare women for breastfeeding. A recent Cochrane systematic review of antenatal-only breastfeeding education found that the quality of the evidence was too poor to recommend any specific form of antenatal intervention over any other (Lumbiganon et al, 2012).

Finding the burden of responsibility as overwhelming has not been explored in relation to breastfeeding in the extant literature. However, loss of former identity in the transition to becoming a mother has been reported elsewhere (Mercer, 2004). Many of the participants in my study felt they had lost some of their self-identity due to breastfeeding, whilst a few felt that breastfeeding helped them develop a positive identity of themselves as a mother. Cultural representations of femininity are of a superwoman who can cope with caring for a new baby whilst also completing domestic tasks and caring for others (Ussher et al, 2000). Citing lengthy hours breastfeeding, lack of routine, an inability to undertake household chores and other family duties, breastfeeding was perceived by many of the women in this study as a chore. These feelings were expressed by both primiparous and multiparous women. The anthropologist Raphael (1973) refers to cultures where breastfeeding is universal and seen as natural, but where women view breastfeeding as '*not automatic*' (p15). Such societies relieve new mothers of routine domestic chores and provide practical teaching on baby care. Whilst data was not collected on participants' family networks, the increasing geographic distance between generational family members has been extensively commented on in the literature, particularly in relation to impact on elderly caregiving. When geographical mobility is combined with the lack of knowledge passed through family generations about breastfeeding, it is easy to see how women can feel ill prepared, inadequate and overwhelmed.

Having covered the first of the key themes of this thesis, in the next chapter I will discuss the second theme, illusions of compliance.

CHAPTER 6

ILLUSIONS OF COMPLIANCE

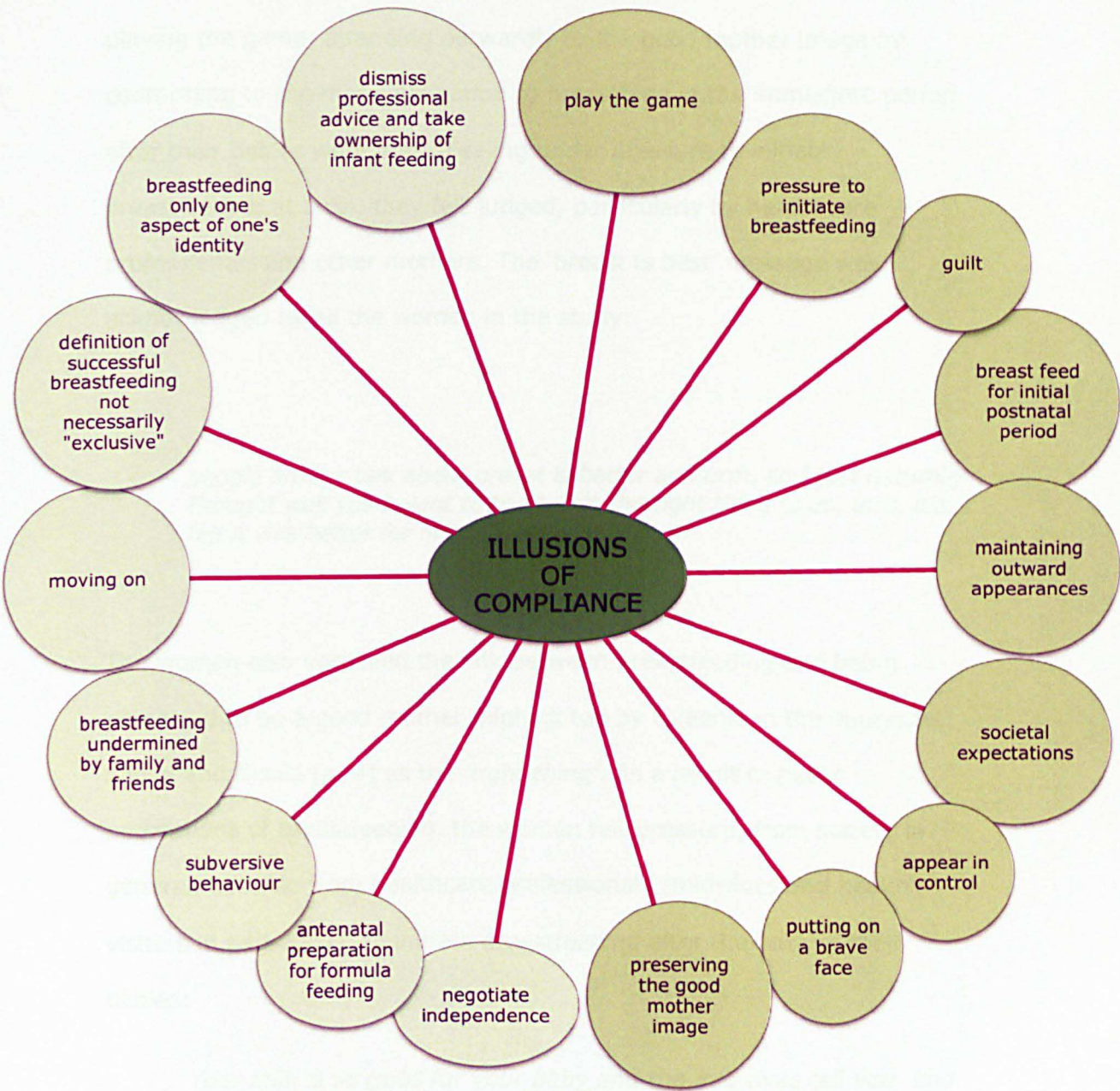
6.1 INTRODUCTION

In this second theme women described how they felt pressured to initiate breastfeeding in order to comply with societal expectations and those of the health care professionals. They also maintained a public pretence in relation to how they themselves were feeling about breastfeeding, putting on a brave face in order to maintain outward appearances and present themselves as in control and coping in their new role, even though they may not have felt in control or as if they were coping.

In this theme the women expressed feelings of guilt if they stopped exclusive breastfeeding, or if their baby was not gaining weight or settling between feeds. Some of the women felt undermined by family and friends regarding their breastfeeding ability, particularly if their baby appeared unsettled between feeds or fed frequently. The women described their own management of infant feeding, taking ownership from the methods and guidance advocated by some health care professionals. Maintaining an illusion of compliance, they did not adhere strictly to breastfeeding information provided by health care professionals, which they viewed as rigid and inflexible, but sought a pragmatic approach to infant feeding that met not only their baby's needs, but also their own and those of the whole

family. This interpretation reveals that women deliberately and strategically maintain a pretence with breastfeeding to meet cultural ideals of motherhood.

Figure 5: Thematic spider diagram showing main 'illusions of compliance' theme and sub-themes



'Illusions of compliance' sub themes	Colours of sub-theme codes
Playing the game	
Breaking the rules	

6.2 SUB THEME ONE: PLAYING THE GAME - COMPLIANCE TO HEALTH CARE PROFESSIONALS AND SOCIETY

Women maintained their normative place as a good mother in society by playing the game, attending outwardly to the good mother image by conforming to the moral obligation to breastfeed in the immediate period after their babies were born. Feeling under pressure to initiate breastfeeding at birth, they felt judged, particularly by health care professionals and other mothers. The 'breast is best' message was acknowledged by all the women in the study:

people always talk about breast is better and urm, so I just naturally thought well yes I want to try it, it is the right thing to do, urm, it's, I felt it was better for him [Queenie, p3]

The women also vocalized the link between breastfeeding and being perceived to be a good mother, highlighted by Queenie in the quotation above and Nicola [p29] as the '*right thing*'. As a result of public perceptions of breastfeeding, the women felt pressure, from society in general, but also from healthcare professionals (midwives and health visitors in particular), to initiate breastfeeding after the birth of their babies:

Your milk is so good for your baby and the midwives tell you, and my mum tells me, that it is so good, such a good start [Amita, p5]

However, the intention to breastfeed was not necessarily for any longer than an initial short period:

I thought it would keep them all quiet and I'd do it for a week and then bottle feed...I just thought, to keep everyone quiet, it was what you were supposed to do, I thought oh well I'll do it, but only for a week [Jenny, p10].

'Breast is best' and the health benefits of breastfeeding was influential in deciding to initiate breastfeeding at birth, but not as a motivator to continue breastfeeding. Those women who had bought equipment and formula milk powder prior to the baby's birth articulated a minimal intention to breastfeed, to '*do the right thing*', but no intention to continue past the initial hospital and midwifery input. It appeared that it was acceptable to fail to establish breastfeeding and then switch to formula, rather than make a choice to formula feed from the start

you've fulfilled your obligation to give him a really good start [Lindsay, p6].

as a new mum you want to do everything right, you want to do the best for your baby, you don't want people to think you aren't doing your best for the baby. And I think that's a big part of it. You're made to feel if you're not doing it that you're not doing the best for your baby, and nobody wants to be known as not doing the best for their baby [Isla, p29].

One of the surprising findings from the interviews with the women in this study was the pressure to maintain an outward appearance of calmness and control, hiding the difficulties and struggles they were experiencing with breastfeeding. This stemmed from a desire not to be seen as a failure. An idealised comparison with other mothers, either real or idealised media images, reinforced the notion of a sense of failure should the ability to breastfeed be compromised. For some, this pressure to conform led to them maintaining a public pretence with breastfeeding, particularly with other mothers:

*I didn't go to any of them [local postnatal groups or baby clinics]...
I think fear of what peer pressure could be [Isla, p18]*

Several of the women who had breastfeeding difficulties talked about how these difficulties implied failure. They were reluctant to attend postnatal support groups because they feared being judged for being a mother who needed help. The women hid behind a portrayed image of their breastfeeding experience as calm and coping, effortless and enjoyable. In private, their experience was different and evoked negative emotions. Rather like a swan: serene above the water, paddling furiously below. Many of the women had very high expectations of themselves, and felt significant guilt at not being able to cope, or blamed themselves when they did not manage to live up to their own expectations. Pauline, aged thirty-seven with her first child struggled with breastfeeding in the early postnatal period. She asked the community midwives and her health visitor to check that she was positioning and attaching her baby correctly as she was unsure on discharge from the hospital postnatal ward how it should feel. In front of health care professionals, she admitted to portraying herself as more confident than she felt in reality:

there's something kinda, I don't know if it's that you feel like you're being checked up on, so you know, you don't wanna say oh I'm struggling, because you're kinda passing a test, you feel that you're competent or not...But I feel as well that I kinda, I was being perhaps a bit more confident in front of them than I actually felt [Pauline, p16].

Pauline was not the only participant to portray herself as more confident and capable with breastfeeding than she felt:

I didn't want to cry and them [health care professionals] to think I wasn't coping [Jenny, p6]

it was just this sense of it would look as if you weren't coping, as if you weren't in control and I wanted it to look like we were coping and we were doing fine and it was almost as if that was something that I should appear to be. Everything was all sorted and look the baby's fine...I tried to make it look like I was coping [Lindsay, p11].

The women experienced feelings of guilt for stopping breastfeeding:

it's amazing how guilty you feel just about something like feeding him [Isla, p22]

but also if they did not enjoy breastfeeding, or benefitted from a brief respite if their infant was supplementary feeding. Lindsay described the guilt she felt from the personal benefit of not breastfeeding exclusively. However, her own mother had died unexpectedly a week after her son was born, and therefore she had introduced a bottle of expressed or formula milk from that point in anticipation of needing to leave him with someone whilst she attended her mother's funeral:

I felt a little bit guilty because I was pleased that the bottle was enabling him to go more through the night and I think there was that slight sense of so you're benefitting from having some sleep through the night although so is Liam, do you think you're doing it for him or are you guilty because you're getting the benefit out of it as well [Lindsay, p17]

However, the women also felt there was a lack of professional support when they wanted to stop breastfeeding, even when their reasons for

wanting to stop breastfeeding were articulately rationalised and justified. Georgina breastfed for over five months, of which she was exclusively breastfeeding for the first four months. She was returning to work full time as a physiotherapist when her baby was 8 months of age, and did not want to supplementary feed or breastfeed to any extent when she returned to work. She discussed her plans to have her son completely settled on formula milk and weaning foods by the time she had to do her first shift back at work.

the hardest thing I found was stopping...I'm not going back to work for another six weeks, and I suppose I could have carried on a little longer but I was concerned it might take some time... People don't want you to stop...'you know you don't have to stop to go back to work', But I was like well I think I want to stop...if I had only done it for three days I could understand people well saying, encouraging you in that sort of way, but I, I had done it for a good old length of time, I had a reason why I wanted to stop, I'm quite a sensible person, so I was slightly disappointed that no one wanted to help me to stop. You need help to stop [Georgina, p5]

6.3 SUB THEME TWO: BREAKING THE RULES IN INFANT FEEDING - COMPLIANCE TO FAMILY AND FRIENDS

The women described being '*naughty*' [Georgina, p2], in their management of infant feeding because breastfeeding advice given by health care professionals was felt to be a rigid set of rules that should be strictly adhered to. The women devised their own methods for integrating breastfeeding into family life, such as mixed feeding (any combination of breastfeeding, breast milk in bottles and formula feeding), prolonged use of nipple shields, early introduction of supplementary foods or early

cessation of breastfeeding. The construction of breastfeeding by health care professionals as rule-based and regimented resulted in the women not seeking out advice or support from them when they had questions or needed support with infant feeding.

The women in this study rarely stated that their decision to stop breastfeeding was solely one of personal choice. In the first few minutes of the interview, Nicola described how she felt guilty when she stopped breastfeeding and talked about needing that decision to be sanctioned:

my mum said she's not getting enough which she clearly wasn't and you're not getting a rest, there's no point in taking it to the point where you're not enjoying her and she's not having enough [Nicola, p1]

At the time of data collection she had two children, having formula fed her first baby from five weeks of age, but with her second child she had introduced occasional formula feeds at three weeks and was completely formula feeding by four weeks of age. Nicola also described how she felt more guilty with her second child, emphasising that not breastfeeding a female child was more guilt-ridden than not breastfeeding a male infant. In this study, Nicola was the only participant to express any comments regarding the sex of her infant in relation to breastfeeding.

Some of the women felt undermined by their family and friends regarding their breastfeeding ability. This was particularly noted of grandmothers (maternal and paternal), who were reported to cite the unsettled behaviour of the infant between feeds as indicative of insufficient milk or poor breastfeeding technique:

even my mum, she sort of said to me I really think she'd be better if you put her on the bottle. Your breast milk isn't enough and I think you'll see a difference in her [Octavia, p9]

she [maternal grandmother] said well maybe your breast milk isn't enough for him, maybe he isn't getting enough sort of thing, why don't you try a bottle [Michelle, p13]

The women also described how the introduction of formula milk feeds would involve their partner in the feeding experience

so my partner could feed, cos Noah's [eldest child] not his you see, this [baby] is his first, so he could be a part of it [Nicola, p13]

Queenie talked in depth of how her infant's unsettled behaviour between breastfeeds reinforced to her and her partner that their son was not thriving on breastmilk. She felt the decision to discontinue breastfeeding needed to be sanctioned, both by health care professionals and by her partner. She also emphasised that the brand of formula was the same as that used in the hospital, an attempt to offset her rule breaking and preserve her good mother image

I kept saying to the health visitor that I didn't mind going the other way if it was better for him. So I bought some, I bought a tub of the same formula as we'd been using in the hospital, I tried him on that, and it seemed to work miracle...he was sleeping and he seemed content and he went two hours between feeds and he was putting on weight [Queenie, p13].

Queenie agonised over the decision to wean her son completely onto formula feeds. During the interview she spoke in-depth of the difficulty that decision had been, and of living with the failure to portray the image of the good mother with the perfect infant. Her decision to use the brand of

formula she had seen used in the hospital was cited in mitigation against the decision to wean onto formula feeds.

Successful breastfeeding was not necessarily the same definition for women as for health care professionals. For some of the women interviewed, breastfeeding was deemed successful even if it was not done exclusively. Breastfeeding plus some formula feeds was deemed an acceptable alternative for some women, despite not being advocated by midwifery or health visiting staff. Jenny, first time mother, introduced occasional formula feeds at three months, and was still supplementary feeding at the time of data collection when her baby was just over four months of age. She described how the occasional formula feed gave her some rest, and it was this that she credited with recharging her energy levels in order to continue breastfeeding. Jenny felt that otherwise she may well have stopped breastfeeding altogether. Her experience contradicted what her health visitor and community midwife had implied would be a slippery slope leading to stopping breastfeeding altogether

I find that because of the bottle she's slept better and I've slept better and I just deal with it a lot better...because I wanted her to keep having a bit of breast but I wanted a bit of freedom...I was thinking that, if she [other mother at postnatal group] hadn't said I could give her one bottle I was going to stop and give her all bottles [Jenny, p14].

Jenny was not the only participant to supplementary feed, and credit that combining breastfeeds and occasional formula feeds provided respite that enabled them to continue any breastfeeding

we can deal with the rougher times during the day [Octavia, p15].

Expressing breastmilk was constructed as a means of allowing a degree of freedom in terms of being able to go out or do other things, as a method of having a break from the demands of motherhood and also resuming other tasks and activities. Michelle, who had been expressing her breast milk since her baby was six weeks of age, said she expressed so that she could have an occasional night out with her husband and also recommence personal fitness activities

I do tend to wish him asleep so I can get on ...it is a case like I say of developing a life as well as having a baby [Michelle, p20]

Kelly, who was breastfeeding her second child at the time of the interview, was uncomfortable breastfeeding in public and initially timed going out around the baby's breastfeeds. She was advised against expressing in the early postnatal period by her health visitor who cited '*they [babies] get confused about sucking on nipples, teats and things*', but Kelly dismissed this advice and expressed each day from her youngest being four weeks of age so that she could go out in the evenings with her friends and leave the baby with her partner

I don't want to be tied down to feeding her all the time [Kelly, p23]

Octavia, mother of two, breastfed her first child to five weeks and expressed regret at introducing formula feeds with her second baby, but also jealousy of women who were exclusively breastfeeding

I felt so close to her whilst I was feeding her, so yea I suppose I do feel a little bit that way, a little bit jealous, yea, I wish I could have carried on [Octavia, p9]

For Octavia, breastfeeding was felt to be only one aspect of her identity, only one aspect of her role as a mother that she felt the need to 'move on from' [p9]. She spoke in her interview of 'returning to normal' [p30], having earlier in her interview describing how she felt confined to the house when exclusively breastfeeding, partly because she was not comfortable breastfeeding in public, but also because her baby would breast feed in stops and starts. Octavia introduced occasional formula feeds so that she could spend exclusive time with her eldest daughter, and also spend some time on herself, giving the example of having a 'cut and blow dry' [p31].

Rebecca found breastfeeding her second child easier than breastfeeding her first child. She found the first six weeks particularly painful and uncomfortable, but with a determination to succeed and advice from a community midwife recommending she try nipple shields, she was exclusively breastfeeding at the time of the data collection interview, and was intending to continue breastfeeding until her son self-weaned.

one of the midwives said look I'm not supposed to recommend it, but have you tried nipple shields?.... if that midwife hadn't suggested the nipple shields when I had Reuben, I'm not sure what might have happened [Rebecca, p8].

Rebecca was not the only woman to continue breastfeeding whilst using nipple shields. Belinda also reported using them sporadically when her nipples were sore and painful

My nipple was really sore, cracked from the feeding, every time that I was feeding him. In the end, I know you're not supposed to, but you know those shields, they don't advise you use those shields, but it was so painful if I hadn't used them I would have given up because I was, oh it was horrible. But the shields did help, just putting them on every so many times, not every time, but just to give me a rest because I'd been feeding so much. Um, so yea, they did help [Belinda, p17].

Some of the women described their own management of infant feeding that went against that advocated by the health care professionals, for example supplementary feeds of formula milk and early introduction of solids: Georgina avoided asking her health visitor for feeding advice as she thought they would not approve that she had already started to wean her son onto solids before the Department of Health (2003) recommended introduction from six months of age

I was naughty and started him on a bit of baby rice I did. I just couldn't physically do the two hour feeds...I suppose I pulled back from asking the professionals about it because I thought, they don't want me to do this, so just work it out [Georgina, p2].

Georgina described her actions as 'naughty', whereas Charlotte expressed dissatisfaction that the advice from health care professionals was focussed solely on exclusive breastfeeding

I wish someone could have told me that I could have, um, bottle feed and breast feed....If they are told its tough, and on the forum every two, four, six, eight and twelve weeks women are there, please help me and if they were told, it is possible to combine, I think you would get a lot more women [Charlotte, p8].

6.4 DISCUSSION

The women in this study were aware of the health benefits of breastfeeding, but despite this knowledge, not all the women appeared determined to exclusively breastfeed. This concurs with previous research which suggested that knowledge does not necessarily translate into practice and sustained action – continued breastfeeding (Hoddinott and Pill, 1999; Lavender et al, 2005; Twamley et al, 2011). Gabrielle Palmer (2009) is critical of the 'Breast is Best' mantra, arguing that it normalises artificial feeding and presents breastfeeding as an added extra, as opposed to being the normal way to feed a baby. The benefits of viewing breastfeeding as the norm rather than as better-compared-to-the-norm have also been recognised by the Breastfeeding Network, who in 2010 encouraged the government to rethink its 'Breast is Best' slogan on the basis that it fails to motivate women to breastfeed. The chair of the Network, Lesley Backhouse, wrote to the Department of Health complaining that the slogan *'implies something special, whereas breastfeeding is the physiological norm, and suggests that formula is the standard way to feed babies'* (BBC, 2010). Decisions to breastfeed are generally expressed as an intention to 'try', with formula feeding seen as a reliable back-up option (Bailey et al, 2004). Callaghan and Lazard (2012) explored the cultural context in which infant feeding choices were made.

Women defend their switch to formula feeding in order to care for their children, illness, and pressure from their family, a viewpoint that is shared by several authors (Murphy, 2000; Marshall et al, 2007; Groleau and Rodriguez 2009; Hoddinott et al, 2012). Data from this study supports these findings, that women prioritise the family unit over baby-centred infant feeding. Maintaining an illusion of compliance, they did not adhere strictly to the breastfeeding guidance and advice provided by health care professionals, which they viewed as intransigent. They articulated the ways in which they ignored or dismissed advice from health care professionals for example with regards to supplementary feeding. These decisions were justified as pragmatic approaches to infant feeding that met not only the baby's needs but also their own and those of the whole family. A lack of peer and family support for exclusive breastfeeding, combined with the rigid and inflexible approach to breastfeeding espoused by health care professionals, led to the perception that exclusive breastfeeding did not fit with family life and was an unrealistic and unattainable ideal.

Findings from this study indicated that some women maintained a public pretence in relation to how they themselves were feeling about breastfeeding. They presented themselves as a coping mother, even though they may not have felt like one. This stemmed from a desire not to be seen struggling, not to be seen as vulnerable or a failure. This was particularly noted in the descriptions of older, primiparous mothers (Pauline and Lindsay). An idealised comparison with other mothers, either real or idealised media images, reinforced the notions of a sense of failure should the ability to breastfeed be compromised. Putting on a brave face was reported as a coping strategy. Analysis also showed that rather than be supported to overcome these challenges, the women's social withdrawal

further perpetuated this. Whilst this is not a finding that has received attention in published breastfeeding studies, there are examples in studies of women with breast cancer (Gonzalez and Lengacher, 2007), mothers with rheumatoid arthritis (Mitton et al, 2007) and women with postnatal depression (Letourneau et al, 2007). In these studies women were found to put on a brave face in order to mask or deny the impact of symptoms, to stay in control, and project an image that was acceptable to family, friends and health care professionals. Hunter (2005) suggests that although the use of covert strategies in order to play the game may have short term success, the need for continued pretence and impression management creates dissonance and frustration, particularly when there are ideological conflicts. These findings reflect cultural representations of femininity that are of a superwoman who is able to cope with competing demands (Ussher et al, 2000).

Those women who articulated taking ownership of infant feeding management were demonstrating resistance to the ideology of motherhood and therefore agency. However, whilst subversive practices demonstrate individual agency, this was limited as not disclosing these infant feeding behaviours reveals the difficulties women had trying to establish themselves as authoritative experts in the management of their own child's feeding.

The level of distress and guilt associated with stopping breastfeeding before women wanted to appears profound. It also seems that women experience fear of sanctions or criticism from health care professionals, and this seems to inhibit them from seeking help. This has been reported

in a previous study, although comprised a three line quotation and no explicit discussion. In Barclay et al's (1997) grounded theory study of 55 women's experience of motherhood, one participant was quoted having hidden the decision to stop breastfeeding from her health care professional (*'I had to lie'* p727). In Lee's (2007) study, the women hid that they were supplementary feeding, or even giving expressed milk in bottles, from health care professionals. This may be related to infant feeding being presented as a dichotomy, breast or bottle, and the perception that health care professionals are solely breastfeeding centric (Fenwick et al, 2013). There is a social expectation that mothers will behave favourably (choose to breastfeed) and attend to their child's needs with total disregard to their own (Flacking et al, 2006). One of the participants from Hoddinott et al's (2012) study concurs: *'It all seems to be, 'don't ever do anything that would interfere with breastfeeding', it's all got to be very purist which is fine, but it just doesn't fit in with the rest of your life and I think in a way people just give up because it's too difficult (p7)'*. This has profound consequences for the role of health care professionals in supporting women with infant feeding in the postnatal period.

Having covered the second of the key themes of this thesis, in the next chapter I will discuss the third theme, tensions and mixed messages regarding breastfeeding.

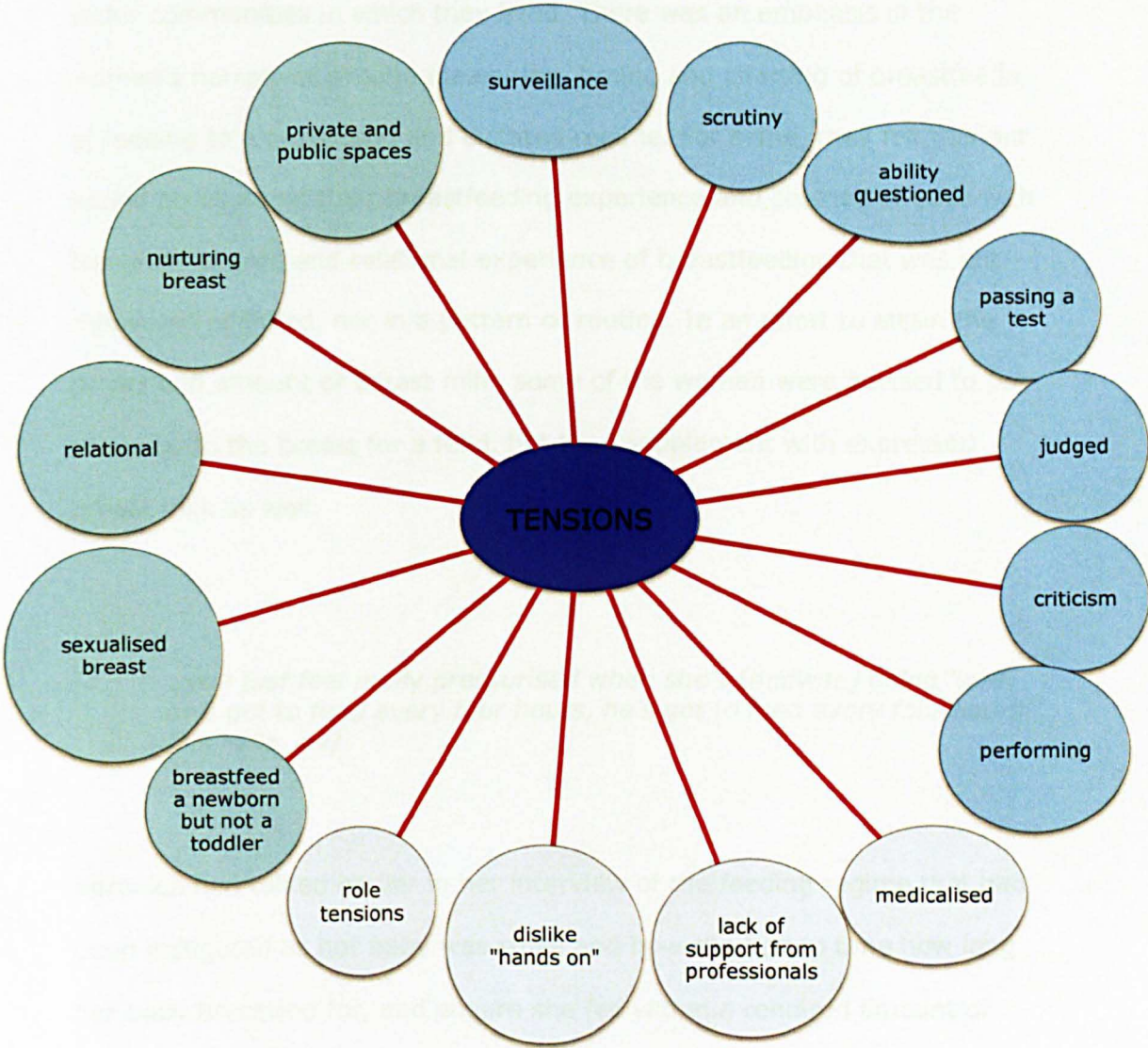
CHAPTER 7

TENSIONS

7.1 INTRODUCTION

In this third theme, the women described tensions and mixed messages regarding breastfeeding – feeling scrutinised in their ability to breastfeed their own infants, contradictions between public health messages promoting breastfeeding and the health care professional support received to facilitate breastfeeding continuation, and cultural constructs surrounding conflicting viewpoints of breasts as sexualised and nurturing, images of breastfeeding in terms of the age of the infant, and about how breastfeeding is perceived in shared public spaces such as shops, pubs and workplaces, but also in their own homes. The women also described how these approaches and messages impacted on their breastfeeding experiences, and how they managed breastfeeding as a result.

Figure 6: Thematic spider diagram showing main 'tensions' theme and sub-themes



'Tensions' sub themes	Colours of sub-theme codes
Surveillance and scrutiny	
Conflicts and contradictions	
Cultural constructs	

7.2 SUB THEME ONE: SURVEILLANCE AND SCRUTINY

The women in this study described feeling scrutinised in their ability to breastfeed, by health care professionals, but also by their family and the wider communities in which they lived. There was an emphasis in the women's narratives around measuring, timing and charting of breastfeeds, of feeding to a prescribed and dictated regime. For some, they felt this put added pressure on their breastfeeding experience and seemed at odds with the unstructured and relational experience of breastfeeding that was not measured or timed, nor in a pattern or routine. In an effort to attain the prescribed amount of breast milk, some of the women were advised to put the baby to the breast for a feed, but then supplement with expressed breast milk as well.

*...you just feel really pressurised when she's [midwife] going 'well he's got to feed every four hours, he's got to feed every four hours'
[Michelle, p4]*

Veronica had talked earlier in her interview of the feeding regime that had been instigated as her baby was small and how she had to time how long her baby breastfed for, and ensure she fed within a required amount of hours. This led to Veronica feeling as though she was constantly clock watching. Additionally, she described feeling as if she had to demonstrate performance to the professionals' satisfaction before she would be permitted to be discharged home

On the feeding chart she had to feed every, for, I think it was twenty one minutes out of every three hours, I don't know how they came to that figure, but as long as every individual feed added up to twenty one minutes every three hours we could go home after three days, and we was also charting her wet nappies, the dirty nappies [p10]...I think the number of people that watched me feed her was quite amazing, all the various midwives and the feeding team and I think there was someone else, I didn't know who the people were in the end [Veronica, p26]

Pauline, also a first time mother, also described feeling as though her performance as a breastfeeder and as a mother was being judged and assessed by the health care professionals

You feel like you're being checked up on, so you know, you don't wanna say 'oh I'm struggling', because you're kinda passing a test, you feel that you're competent or not [p15].

The women expressed their desire to go home from the postnatal ward as soon after the baby's birth as they were able to, in part because the ward was so busy and noisy it was not felt to be conducive to postnatal rest, but in part so that the women were able to get away from feeling as though they were under surveillance. As a result, the women did not have the competence and confidence in their own abilities with breastfeeding when they got home.

Sharon, who had breastfed her first child until three days before her second was born, resorted to force breastfeeding to overcompensate when her baby had lost weight from his initial birth weight when the community midwife weighed him on a routine postnatal home visit. As is local policy, Sharon had been referred to attend the children's ward by the community

midwife due to the weight loss of over ten percent. However, the weight loss had been wrongly calculated, but the experience led Sharon to question her ability to breastfeed sufficiently for her growing infant. The community midwife advised Sharon to supplement with formula after each feed in an attempt to ensure weight gain was satisfactory from that point onwards, but when Sharon declined to adhere to this advice, she felt criticised for not adhering to the advice she had been given. In an attempt to prove that she was capable of attaining the specified amount of weight by exclusively breastfeeding she resorted to unremitting breastfeeds, regardless of the baby's demands

I completely felt I was failing my child, he's losing weight, he's getting skeletal, oh my God what have I done and yea I was in floods of tears and the doctor came in and he said I suggest your midwife get a calculator, he said it's 8 percent of the body weight lost, not ten percent, you're fine, go home [laughs] but I was so paranoid and they said they were gonna come out every day after that to weigh him because they were really wanting to monitor him so closely, so the poor lad was drowning in milk. Every two seconds I was going feed, feed, feed, I felt like I was trying to feed him constantly, he didn't want it, he was I'm full mum stop it, but I was literally forcing it on him, thinking you've got to gain weight, you've got to gain weight. I was actually shaking when they came round with the scales, it was like, oh God, my blood pressure must have been sky high [Sharon, p19].

Data analysis indicated that mothers experienced considerable problems that arose from relationships between them and the health care professionals. There were extensive accounts of the negative effects of criticism from midwives and health visitors. Denise, a first time mother at the age of nineteen, found the support from the hospital midwives uncomfortable and distasteful, particularly the hands on approach to latching her baby onto her breast. She described eight postnatal days spent in the hospital where her daughter was supplemented with cup feeds

of formula milk. She felt a failure as a mother, and on discharge she admitted that she *'didn't have any idea how to put her on myself'* [p3]. Her baby was slow to gain weight, and she described feeling judged by the community midwives

[Denise] ...they [community midwife] called it failure to thrive because she'd gained an ounce in five days and they said that wasn't good enough [pause]

[Interviewer] So the community midwives, saying that wasn't good enough, what wasn't good enough?

[Denise] Yea...um...it was...well...how much weight she was putting on [p6].

Denise subsequently chose to attend a lactation clinic and consulted a breastfeeding counsellor who advised minor changes to the way in which Denise was positioning her baby at the breast to feed. She reported satisfactory weight gain from that point onwards.

Tanya, aged sixteen, single and living with her parents in an area of social deprivation, described needing help and advice for breastfeeding when she was on the postnatal ward after her baby's birth. She described having difficulties for the first two days and that her baby was reluctant to feed

they [midwives] did tell me, oh you're doing it wrong [Tanya, p8].

Tanya was not the only participant to relay descriptions of feeling criticised or chastised by health care professionals. Elizabeth, describing how she had expressed some breast milk because she had such an abundant supply she was concerned she might drown her baby, and having been shown how to express by the hospital midwives, assumed this was the solution. She felt reprimanded by the community midwife when informed of Elizabeth's actions

oh no, you shouldn't have done that [p8].

7.3 SUB THEME TWO: CONFLICTS AND CONTRADICTIONS

The women spoke of tensions between their roles as wife (partner) and mother. This was a difficult transition for first time mothers who described having to continue to fulfil their obligations as a wife (partner) in addition to their new role as mother. Some of the women who were anticipating a return to paid employment also envisaged further tensions in accomplishing the role of worker / employee. Octavia introduced formula feeds as she felt that breastfeeding the baby was too time consuming and necessitated her having less time with her eldest child, impacting on her responsibilities as a mother to her eldest daughter. She gave an example of how taking time to breastfeed after breakfast had meant that they had been late doing the school run one morning. Nicola felt similar conflicts between her role as mother to a school-aged son and breastfeeding her newborn daughter:

it is quite difficult on Noah because I've got to take him to school and I've got to take him at certain times [p3].

Acknowledging that breastfeeding is a key public health concern, efforts have been made internationally, nationally and locally to strengthen breastfeeding support, including ensuring all health care professionals are confident and competent to support breastfeeding. What was surprising from the women's accounts was how they perceived, described and interpreted the support they received from their midwives and health visitors. The women's accounts expressed that they recognised how busy the hospital midwives were:

Midwives obviously they don't have the time, I know that. I know how understaffed they are, completely [Jenny, p6]

The women recognised that they would require support to breastfeed, and assumed that this support would be offered in a plentiful supply given the public health importance ascribed to breastfeeding, particularly on the postnatal ward from the midwifery team. However, their experiences were predominately that this was not the case, and indeed many of the women expressed that help and advice for breastfeeding was not forthcoming in the hospital:

in the hospital, it's so much coming and going and things, there was no continuity at all, they'd just pop in and say are you alright, do you know what I mean. There didn't seem to be anyone sort of specifically dealing with that [breastfeeding], which I think would have been better, if there had been a couple of people just dealing with that, it would be better [Pauline, p12]

sometime they say they are coming but they don't come for half an hour and they forget to come sometime [Amita, p3]

Isla, who was finding breastfeeding very difficult, blamed the lack of support for breastfeeding by the midwives in the hospital for contributing to her not managing to establish breastfeeding. She described her concerns about whether her newborn son was getting sufficient breastmilk, and that the midwives would not teach or demonstrate positions for breastfeeding but would physically attach him at her breast and then leave her alone with him to continue the feed:

Every time I pressed my buzzer they were like 'yea, yea we'll be there in a minute, we'll be there in a minute' and they'd come and turn your buzzer off but didn't come back... I think if I'd been given the proper breastfeeding support in hospital, it might have well been a different story. There just weren't enough staff to do it, to help. There just weren't [Isla, p3].

Kelly had formula fed her first child, and although she said that the midwives knew that this was her first experience of breastfeeding, she felt that she was treated differently because she was a health care professional (an adult nurse). She felt that the way in which the midwives communicated with the women on the postnatal ward resulted in her not feeling as if she could be honest about her difficulties with positioning, attachment and concerns over her milk supply:

They didn't really ask you the right questions... I didn't want to seem like everything wasn't alright, partly because I just thought if you can't ask me if I need help, why should I, why should I come running to you sort of thing when you can't ask me is everything alright do you need anything. I didn't feel as if I could ask them [Kelly, p26].

The women described a lack of consistency in the advice they were given, which they ascribed to the lack of continuity in carer. This seemed to result in the women not feeling as if they had a rapport with both the hospital-based and community midwives:

I never had the same midwife more than twice [Elizabeth, p6].

Every different midwife had a different thing to tell me and a different idea of how to latch him on and, urm, and one of them would say don't do that, do this and the next shift would come on and I'd say the lady this morning said to do it like this and they'd say well yes, yes, that was the old way, that was how we used to do it but now we find if you try it like this, and it was just too much information and there was no continuity and I don't think it helped me at all trying to get him [baby] to, to feed [Rebecca, p14].

The support for breastfeeding the women did experience was not welcomed. The women spoke of an overwhelming dislike of the physical help they received to latch their baby, to the point that women avoided being honest about the help they needed. The women found a health care professional touching their breasts daunting, intrusive and distressing, which hindered their ability to initiate and maintain breastfeeding. Georgina described the midwife who latched her son on for a breastfeed on the postnatal ward as 'pawing at me' [p3].

I remember it was about 9 o'clock in the morning after I'd given birth I thought, well I'm ready to feed my daughter now. And I buzzed for a midwife because like, never doing it before, you know, how do I latch her on properly, and the midwife came in and she had me laid down on my side which was very uncomfortable for me like that, I didn't really like that, and she got my nipple [makes squeezing motion between thumb and first finger], squeezing it [made grimace with face], it did not feel good at all [pause]... And she latched Daisy on and said 'well she should be on there for a good hour, and...um...no sooner had the midwife walked out the room and she came off again and I thought 'Oh my God, how do I get her back on', so I buzzed her again and she put her back on

again and then kinda...the same thing happened again...she kinda fell off and I was like..what do I do now, I can't keep buzzing every five minutesI didn't have any idea how to put her on myself, I was like 'how did they do that' it was uncomfortable on my side and I really could not do it. So they squeezed and got her latched on, and then she'd fall off as soon as they left the room [Denise, p5].

They [midwives] didn't show me any positions, they literally just popped him on....She [midwife] just grabbed me and started doing it. I was like that, whoa [Isla, p29].

They [midwives] come along and grab you which is quite...It was quite an invasion of my personal space, you know. And I do, I preferred the midwives who offered advice rather than the ones who grabbed him and grabbed me [Michelle, p36].

Charlotte, who had disliked the physical help to latch her previous baby on the breast, admitted to pretending she was coping when in hospital after the birth of her third child in order to avoid the physical assistance:

I think I didn't want to feel like I did, because when I was the first time, with Charlie, they kinda took over, and they grabbed me, and grabbed Charlie. They were trying to help, they weren't doing anything wrong, but they just made me feel, urm, I'm here, and they were like, do you mind if we hold the boob, and I was like no...I wanted to do it, and he latched on so well and they just assumed, that, you know because he did it so well.

[Interviewer] And you let them, ur, assume you had breastfed before.

Yea.

[Interviewer] Because you didn't want them to, ur, physically grab you or Christopher to latch him on?

Yea, I didn't want that to happen, yea [Charlotte, p10].

The majority of the women in this study had not been exposed to breastfeeding prior to having their own babies. They needed to know how to position and attach their babies at the breast before being discharged

from hospital. However, they described both not having confidence or feeling competent at positioning and attachment prior to their discharge from the postnatal ward, or adequate support with breastfeeding when they were at home, from their community midwifery team or their health visitor.

I expected them to help me a lot more, because of him, the importance they place on breastfeeding, and knowing that he wasn't breastfeeding... she [health visitor] said I wouldn't see her again and I'd have to go up to the clinic. She gave me a little sticker with the times the clinic was on. I thought the midwife was going to come back. I didn't realise there was nobody coming again [Isla, p26]

Health visitors seemed to fare particularly poorly in the women's descriptions of care and support for breastfeeding. Veronica had contacted her health visitor to request help with breastfeeding, but felt isolated and unsupported:

She [Health visitor] said oh well someone will ring back and no one did ring back and urm I felt like I was left to do it on my own a lot [p3].

I think it's [breastfeeding support] tailed off a bit now with the health visitors [Kelly, p2].

Baby clinic was described as a conveyer belt that was predominately concerned with weight surveillance rather than a health care professional contact. Some of the women described having their baby's weight called out across the room whilst the baby was being re-dressed, and was therefore audible to everyone else in the room. For some women, this was distressing if their infant had not put on the required weight as they felt

their ability to breastfeed was called into question, and they felt further discouraged by the clinic set-up from asking for support or advice from the health visitor:

it was all very much, here's your number, go, you get them changed, you put them on the scales, they write it in your book, there you go. Thank you. Off you go. It was, well when do I ask if there's anything, there was nobody else there, there wasn't anybody else there in the room floating around saying, to come and talk to you, you know while you're sat there waiting to get them undressed, there was nobody there to come and say oh hello I'm so and so, I work for such and such a surgery, there was nobody....it was very much rushed, you're there to get weighed and off you go...and it was sort of half past two and you know it was very much, oh OK, and that was it. You're sort of weighed and shoved out the door...she [health visitor] sort of wrote it all down on the chart, everything alright, and it was sort of the way they said everything alright, it's fine. I thought you haven't got time. You haven't got the time to ask me properly, so you didn't want to say I need to speak to somebody [Kelly, p31]

There was a clear sense within the women's accounts that breastfeeding information, advice and support was either unavailable or somehow fell short of what they needed to manage specific difficulties. Only one of the women interviewed knew the name of her health visitor. This resulted in Rebecca and other women seeking their advice and support for breastfeeding from organisations such as the National Childbirth Trust and online support groups. Two of the women (Charlotte and Sharon) discussed at length the support and advice they received from using online discussion groups. They valued the 24-hour availability offered, but also the degree of anonymity it afforded, which they felt was conducive to openness and candour amongst the discussion group members. The frankness of responses to questions, requests for advice and general discussions about breastfeeding with other women who were perceived to be comparable was felt to be trustworthy and sincere

it's not face to face; I'm never going to see them again. It's a nationwide forum. You can go on it 24/7, so if you're having a night tearing your hair out, there'll be someone else on there tearing their hair out, it's just nice that you can say, we can get through it, let's just get on with it, we can do it, one more hour, one more minute [Charlotte, p14]

Participants felt that healthcare professionals stipulated a rigid set of rules for breastfeeding methods and techniques. The process of seeking specialist support was constituted in terms of struggle, revealing tensions between expert knowledge and mothers' experiences. A medicalised approach to breastfeeding management was described by many of the women, particularly in the accounts of those women who were no longer breastfeeding at the time of data collection. For these women, their descriptions of their breastfeeding experience were interspersed with accounts of charting their baby's infant feeding patterns, timing breastfeeds (both the time taken actually breastfeeding in addition to feeding at prescribed intervals), and learning 'how to' breastfeed in a step-by-step mechanistic technique that if one component was not adhered to, would result in failure.

Health care professionals were described as not taking a woman's experiential knowledge into account. Fiona, mother of three, described how she was advised to supplement breastfeeding with formula when her second baby lost weight in the initial postnatal period. She refused, and described what happened

They were panicking over nothing. My milk came in the next day, thankfully [laughs]. And we've not looked back since....It felt as though I knew more about it than they did. I suppose I do really. I certainly do now [Fiona, p6]

Healthcare professionals made assumptions about the women, particularly if they appeared to be coping with breastfeeding in terms of not requesting advice or assistance. Advice and support was therefore not offered proactively, and some of the women in the interviews expressed that they did not feel confident to voice their concerns or need for help.

And I think it's probably because I was getting on with it that they just didn't bother [Sharon, p3].

Multiparous women in particular felt their breastfeeding support needs were neglected and overlooked:

Because I'd done it the first time they assumed I knew how to do it properly [Belinda, p2].

If a multiparous woman breastfed, it was sometimes assumed that she had breastfed previously, which was not always the case. Charlotte expressed her breastmilk for her first baby who was born prematurely. She expressed for five days, gave it to him via a bottle, and then stopped completely on discharge home on day six. When her second child was born she gave formula milk from birth. She was interviewed when her third child was three months old. This time she described herself as determined to breastfeed, but felt that assumptions were made:

In the hospital, because he's my third, they just assumed that I breastfed all three.

[Interviewer] The staff assumed you had breastfed your older children?

Urm, because he latched on so well, urm, it all went so naturally well, they just presumed. Oh look, mum knows what she's doing.

And they just presumed.... I think because you were third time, you were just left to it [Charlotte, p12]

Some women felt that there was an assumption from healthcare professionals that women would breastfeed, rather than it being an infant feeding choice:

It was just assumed, as soon as he was here it was get him on [Michelle, p3].

I don't think I was even asked how I was going to feed her. I think it was just assumed that I would feed her [Veronica, p28].

Health care professionals were viewed as undermining the importance of women's embodied knowledge of breastfeeding. This tension was played out through the privileging of expert specialism over mother's knowledge. The advice offered was viewed as conflicting and sometimes inappropriate. Health Visitors reportedly advised supplementing with formula feeds and then early weaning for each episode of static or poor growth. When asked about support from healthcare professionals in relation to breastfeeding, Sharon commented:

Quite negative. Top ups were mentioned on more than one occasion. Yea, it's always the first point of call [p22].

Early weaning in response to slow weight gain was advised to one exclusively breastfeeding mother with her first child. With her second, she stated that this experience of what she perceived to be a lack of breastfeeding support resulted in her 'avoiding them [health visitors]' [Ulrica, p11]. Health care professionals were perceived to be preoccupied

with weight gain, rather than assisting the women to learn the art of breastfeeding, trusting in their body's ability to provide for their growing infant:

Every day, they came every day to weigh him but from that day he was putting the weight on after that, straight away, which is incidentally exactly the same weight loss you've had, eight per cent, but that day they ummed and arhed, but this time she said we need to do a feeding plan and I said I don't think so but she said well I'm sorry but my guidelines say I've got to do a feeding plan, but I've never seen it. It's just sort of stuck in my notes somewhere probably with the midwife and that was it. They're very hung up on weight, obsessed with weights.

[Interviewer] How do you feel about weighing?

I was really annoyed to be honest, because that really, it dented my confidence and it made me very paranoid about weighings and things like that. I then later discovered that of course they are weighing and measuring them on bottle fed baby charts [Sharon, p20]

Several of the women's accounts suggested that they expressed breast milk as a way of being certain about how much milk they were producing or how much the baby was taking. This is evident in Kelly's account of being able to measure five or six ounces of expressed breast milk obtained in five or ten minutes of expressing with a manual pump. Isla equated the amount of expressed breast milk she obtained at each feed (60 millilitres) with the amount she envisaged a formula fed infant would take, and decided that this demonstrated that '*my milk never seemed to come in*'. This seemed in complete contrast to the relational descriptions of breastfeeding apparent in some of the women's descriptions. The first breastfeed immediately after the baby's birth was a precious experience:

It was very special [Heidi, p3].

Self satisfaction was expressed that breast milk was providing the healthiest nutrition for the baby:

I can't believe that I am life sustaining [Denise, p7].

Fiona spoke of her intention to breastfeed until her youngest reached the age of two years. When asked why until two, she replied

This might be my last experience of it, and you might not want it to stop. Some of it is about me as well [pause]. I just sit down, relax and enjoy him, wherever you are [p17]

One woman said she liked the fact that other people could not provide for her baby in the same way when she was breastfeeding. The experience appeared to intensify the bond in the mother/baby dyad and she stated that she felt 'jealous' [p2] when her mother fed the baby her expressed milk when she went out to the hairdresser:

I prefer him to be with me [Tanya, p5].

7.4 SUB THEME THREE: CULTURAL CONSTRUCTS

The women described conflicting viewpoints of their breasts – the sexualised and the nurturing breast. The length of time women were prepared to breastfeed for was influenced by socialisation processes, their own body image and when they perceived their breasts becoming sexual once more rather than nurturing. Sharon's husband was 'resigned' that her

breasts would be used for breastfeeding and therefore primarily for the baby's use rather than for his pleasure for up to two years. Rebecca's partner was also described as unsupportive towards breastfeeding and the exclusivity of her breasts for the baby

my other half isn't overly encouraging when it comes to me breastfeeding [Rebecca, p9]

Georgina described ownership of her breasts in relation to sexualised objects

my boobs were mine and when I met my husband I let him have a look sometimes [Georgina, p2]

Charlotte described how the length of time she was prepared to breastfeed her infant for was influenced by these perceptions

society will tell me. When I start feeling uncomfortable feeding him [Charlotte, p10].

Breastfeeding a baby over the age of six months was generally considered taboo. Whilst breastfeeding in public was not deemed to be socially acceptable, this was described as particularly difficult in relation to breastfeeding older children. These views were evident even in the interviews with women who were breastfeeding at the time of data collection

I just suppose people in the jungle don't feed their young ones for ever, so I actually think once they aren't babies, once they're having carrot sticks [Georgina, p8]

I saw lady who was feeding her child yesterday and the little girl was two maybe three years old. And I thought, oh God, I don't want to feed that long [Amita, p11]

she [friend] fed Nigel until he was two, which personally I wouldn't have done [pause]

[Interviewer] You wouldn't breastfeed a child until they're two?

No, no, I don't think it's right. No [laughs]. No, that to me is a little bit [pause] just me personally I just think you know, I mean it got to the point where he was lifting up her jumper to go, and I just thought, to me that was wrong, I mean I think there's got to be a cut off point and I think it should have been way before then [Nicola, p28]

when I was pregnant all those women who breastfed for years and years, it's so wrong, and I have no intention of feeding him past a year, or once he's weaned... I certainly don't want him to be old enough to ask for it sort of thing [Michelle, p33]

Only one woman articulated a physical reason for not feeding an infant over a specific age. Octavia envisaged difficulties breastfeeding a six month old baby in terms of physical size and weight, and also '*I draw the line at teeth*' [p21]. Sharon continued to breastfeed her son past his first birthday but stopped breastfeeding him in public as he got older because of how she perceived society to view breastfeeding an older infant

I did stop feeding him in public when he got to nine, ten months, because he did look very big but I think that's probably my own hang up. I thought it's alright to feed little babies, but toddlers, but I didn't want to push it in anybody else's face [p13]

A lack of exposure to breastfeeding as a method of infant feeding was a common theme in the women's descriptions of infant feeding. Fiona, having worked as a nursery nurse prior to having her own family, felt well informed about the physiological benefits of breastfeeding to women and

infants, but other than that had little exposure to breastfeeding prior to her own experience

It's sort of a white middle class sport. If it's seen on telly it's just the extremes....It's not what people expect though. You don't see it much on the telly, not really. When you do see it, it's sort of extremes really [Fiona, p13].

Sharon also felt that breastfeeding was not the norm in contemporaneous society

Actually in my family, urm, actually they had problems and my mother was the only one who was a successful breastfeeder...I feel almost abnormal in a way, in today's society, for breastfeeding [p8].

Later on in the interview she also described how, despite the public health messages promoting the benefits of breastfeeding, that it was still perceived as difficult and how that influenced people's expectations of breastfeeding

people assume they're going to fail and I actually saw a lot of that when I was reading the magazines, you know just standard pregnancy magazines, and they were all fairly negative, I mean they extol the virtues of it, but then say but oh yes then there's these problems and I think if people go with the attitude of I'll have a back-up, I might fail, and they go and get bottles and formula and all the equipment to bottle feed, then I think they are more likely to give up [p29].

Sharon was not the only woman to be the first in her family to breastfeed: Tanya and Veronica also had no siblings or mothers who had breastfed with whom to share their experiences

Bottle, all bottle fed. No one in my family has breastfed. I'm the only one. I think everyone's been quite surprised that I'm breastfeeding and most people have assumed that I'm bottle feeding and I've gone round and they've said oh do you need to heat any bottles and I've said no I'm breastfeeding and they've been quite surprised really [Tanya, p3]

like my mum obviously does say you know that basically a lot of people can't feed babies and even though, just because that's what she's been told and if I'd listened to that I probably would have given up long ago [Veronica, p33]

Whereas Ulrica had vicarious experience of breastfeeding, which she acknowledged as finding encouraging

seeing somebody else breastfeeding normalised it, urm, had I not, I don't know if I would have done it for as long as I ended up [Ulrica, p2]

How breastfeeding is carried out in different spaces may be reinforced or challenged by the wider community, both in shared public spaces and in private spaces when other people are present. A common theme in the women's descriptions is the struggle, at least initially, with embarrassment at breastfeeding in the presence of others. Many of the women described how it was acceptable in the communities in which they lived to breastfeed at home but this was not something that was acceptable to be seen undertaking in public, for example in shops, cafes, and pubs. Breastfeeding thus became confined to the domestic (home) environment. The concept of spaces for breastfeeding extended to being seen as a mother, or lactating woman, in the workplace, which resulted in two of the women who were intending returning to work managing their return specifically in relation to breastfeeding.

Jenny timed going out around breastfeeds in order to avoid breastfeeding in public

I wouldn't leave the house if I knew she would need to be breastfed. You know, if we had to go out shopping or do anything, it would be like we had to feed her and then quick, out, get the things and then get back in case she needed feeding [Jenny, p13]

Expressing breast milk was seen as a way of managing feeding in public. Tanya, aged sixteen, found breastfeeding to be more convenient than how she perceived formula feeding to be. However, she did not feel comfortable feeding in front of others and so expressed whenever she went out, as did Kelly

We don't breastfeed in public. Ever [Kelly, p1].

However, the women in this study did not generally articulate the reasons for their discomfort breastfeeding in a public space, and only one (Sharon) cited an incident where she had been called '*disgusting*' in a cafe by another customer. Kelly, who emphatically would not breastfeed in public, talked about how she herself felt uncomfortable and embarrassed if she saw a woman breastfeeding, not about being criticised or challenged or observed for breastfeeding in public

I think that's me though...I personally still know what you 're doing and I personally feel really uncomfortable...I wouldn't want someone to be sat on a table, even three tables away, to be feeling like that [embarrassed] about me, so I don't think I can [Kelly, p4].

Efforts to be discreet for those few women who did breastfeed in public included Rebecca who would not reposition her baby if he was attached incorrectly, discretion overriding comfort

I still get the occasional sort of soreness on the right side, even now, but it tends to be if I go out and I'm trying to discreetly get him to drink but I'm not watching what he's doing and I get, it's like a sort of blister on that side...I've let him stay where he was urm, instead of taking him off and urm, and re-attaching him [Rebecca, p2]

Ulrica described choosing layers of clothing in an effort to avoid her body being exposed when breastfeeding in public. Breastfeeding in a public space clearly took courage, and felt like a defiant act. Georgina talked about feeding discreetly in public becoming more difficult as the baby gets older

he'd expose me while he had a good look round [p3]

and resorted to

pre-empt his feeding, even an hour before [going out] [p3]

Octavia felt uncomfortable breastfeeding in public and avoided going out when she was solely breastfeeding.

I just sort of felt stuck at home...Even going round to some friends' houses I found it quite difficult. Urm, because I just didn't feel comfortable with, with trying to do it, you know, I was sort of worried you know that people would see, and you know obviously you can't help but have to kind of get your breast out when you're latching the baby on, you can't do it any other way, and I was really conscious of that and didn't, didn't feel comfortable doing it out in public. I wouldn't have wanted to go out for coffee with a friend...So I was really just at home [Octavia, p20]

Some women would breastfeed in what they described as breastfeeding-friendly places such as maternity shops or family oriented pubs

you go for some of the more family type places [Pauline, p11]

Others breastfed in obscure sheltered and shielded places, such as returning to the car and using blankets and clothes to shield being seen by passersby through the car windows

I was wanting to find somewhere where I could go in the corner and do it [Queenie, p15]

Some of the women gave bottles of formula in order to manage breastfeeding when they went out in public. Elizabeth would breastfeed in places she considered to be acceptable but also took a bottle of formula as a back-up plan

I don't, I don't actively feed in public. Ever. I go to Mothercare so if I do go into town, I do plan quite carefully and I also um, take a bottle with me, just in case I'm not anywhere near Mothercare...I've got a bottle as well [p12].

On the postnatal ward, women often draw the curtains around their beds in order to breastfeed in privacy. This seems to further emphasise breastfeeding as a private activity that needs to remain hidden from public. Veronica gave bottles of formula when out in public, otherwise she timed going out around breastfeeds. When asked about this, she discussed her experience in hospital on the postnatal ward

it probably all started in hospital whenever Victoria woke up hungry um and with people visiting they would generally go home so it probably all started from that 'oh we'd better leave you, Victoria's hungry' [Veronica, p36]

Charlotte spoke of mixed messages regarding infant feeding, that although bottle feeding is perceived as the deviant method, breastfeeding in public is not acceptable either

even though bottle feeding is considered, you know, and everyone always says they had to turn to bottle feeding, because of various reasons [pause]. Breastfeeding isn't socially accepted either [Charlotte, p13]

Some of the women did not even feel comfortable breastfeeding in their own homes in front of close family, for example Fiona who would not feed in front of 'my parents, or my in-laws'. Michelle described feeding in an upstairs bedroom when visitors were in her house. As a result of being isolated from visiting family and friends, she found herself stopping feeds prematurely

Well it does put me on edge when my grandparents are around. But I find feeding stressful when people are around anyway...And I tend to obviously cut his feed short...Yes, I must admit I don't feed in front of a lot of my family sort of thing... I must admit I'm quite shy about feeding him outside... I just couldn't even entertain the idea of feeding him in front of anyone... I wouldn't feed in front of anyone [Michelle, p11]

None of the women interviewed had returned to work at the time of data collection, except for Michelle who, as a full time undergraduate student, had returned to her studies. However, of the women intending to return to work, none intended combining breastfeeding and working. For example, Belinda described how she would not return to work until she had stopped breastfeeding, and she was unsure when that would be as she had not intended breastfeeding as long as she was doing so

But with him, I've got a reason to stay [at home]. I've got something that nobody else can do [Belinda, p5]

7.5 DISCUSSION

This third theme reveals a contradiction in terms of beliefs about the health benefits of breastfeeding compared to attitudes towards breastfeeding in terms of social acceptability. A patriarchal health care support system was described whereby the women felt under surveillance and expected to perform to a prescribed ideal. The women expressed their desire to go home from the postnatal ward as soon after the baby's birth as they were able so that they could get away from this, but as a result the women did not have the competence and confidence in their own abilities with breastfeeding when they got home. Being uncomfortable with the environment on the postnatal ward and taking an early discharge has been reported elsewhere. In Ryan et al's (2011) study, some of the women described interruption of the breastfeeding space, for example with technical interference or an unsupportive environment – as non conducive to breastfeeding. One women described the mechanistic hands-on assistance she received which she did not like – she felt self-conscious and nervous, and so discharged herself to learn at home, as she described *'with no one watching, so that we could mess it up and it didn't matter'* (p735).

Ingram et al (2002) conducted a prospective cohort phased intervention study at a teaching hospital in Bristol which had low rates of initiation and duration of breastfeeding. Hospital midwives were trained to use a 'hands off' approach to teaching mothers to position and attach their babies at the breast. Data collected at two weeks postpartum reflect significant differences in exclusive and any breastfeeding; at six weeks no significant

differences were detected. Wallace et al (2006) conducted a randomised controlled trial in four hospitals in the East Midlands. Mothers received either routine care or verbal-only advice on positioning and attachment for the first postnatal ward feed. No significant differences were found in the numbers of mothers breastfeeding at 6 or 17 weeks. The authors suggested that 'hands off' care at the first feed may be less important than achieving a first feed, and that other care practices at subsequent feeds may negate the benefits of care at earlier feeds (Wallace et al, 2006, p272). Taylor and Hutchings (2012) reported women's narratives within their educational intervention study whereby two women had expressed a dislike of midwives handling their breasts because they found it disempowering. These women's perspectives are supported by evidence in the wider literature. Dykes (2005) suggests that using a 'hands on' approach can be detrimental to women's confidence. The focus groups in Taylor and Hutchings' (2012) educational intervention study revealed that some participants were shocked that women in the narratives objected to hands on method of support. They were apparently unaware of the detrimental effects on women, despite the evidence suggesting that women dislike this approach to care, finding it distressing and embarrassing (Hoddinott and Pill, 1999; Weimers et al, 2006). As with other studies, having physically attached the baby to the breast, the health care professional then left the babies with their mothers rather than remaining to assist with feeding (Dykes, 2005; Grassley and Nelms, 2008). Data from a recent national survey showed that women preferred to have a midwife with them for the whole of the first feed to help with potential problems (Henderson and Redshaw, 2011). Non-supporting behaviour such as inadequate assessment of breastfeeding technique, rushed behaviour, inadequate or inconsistent advice, negative or judgemental attitudes are perceived by women as unhelpful. If health care professionals sit through

the whole breast feed, they can not only advise on positioning and attachment, but also infant feeding cues and infant behaviours, using the time as an opportunity to talk with the woman about her expectations, support network and perceptions of infant behaviour. This is a different approach to observation from the women's reports of feeling scrutinised in their performance of breastfeeding discussed earlier.

Findings from this study found that experiences of breastfeeding initiation in the immediate period after the baby's birth were overwhelming positive, but experiences of breastfeeding support, both in the postnatal ward and on discharge home were mixed. Three women (Isla, Kelly and Veronica) felt that breastfeeding support was particularly lacking from health visitors, that they were expected to attend the nearest well baby clinic rather than being offered further home visits. However, well baby clinic was described as a conveyor belt that was predominately concerned with weight surveillance rather than a health care professional contact. These findings echo earlier criticisms surrounding the role of health visitors in breastfeeding promotion (Carlisle, 2008). Evidence from a review of nine reviews of home visiting (Bull et al, 2004) identified that programmes of home visiting could be effective in improving breastfeeding rates if they were of medium to long term (at least six months and up to twelve months after the baby's birth). The lack of support for exclusive breastfeeding after the initial postnatal period has received sparse attention in the published literature. However, comments on social media sites such as mumsnet are besieged with comments regarding postnatal ward staff and health visitors' lack of support for breastfeeding. Sachs et al's (2006) ethnographic study found that health visitors targeted interventions (including suggesting giving infant formula) towards increasing weight gain rather than

improving breastfeeding effectiveness, and Robinson (2004) reported that the most common complaints the Association for Improvements in the Maternity Services receive are regarding health visitors' ignorance and misinformation about breastfeeding. Cloherty et al (2004) found that midwives supplemented breastfed babies on the postnatal ward to protect mothers from tiredness or distress. It should be noted however that Cloherty and colleagues collected their data in 2002 on a Unit that had not achieved Baby Friendly status. Midwives interviewed in Furber and Thomson's (2006) study admitted that '*bottles of artificial milk were frequently offered to breast-fed babies*' (p369). More worryingly was the admission from one midwife that breastfed babies were given bottles of artificial milk secretly when the babies were cared for by midwives at night because the mothers were too tired (p369).

The midwives in Furber and Thomson's (2006) study also used communication strategies with selective phrasing to steer a woman to a decision the midwife felt was best according to the midwife's needs and the midwife's perception of the woman's needs. This is an example of paternalism, where the midwife assumes that she knows best, rather than providing information in order for the woman to make a fully informed decision (Walsh, 2005). It could also be suggested that the midwives in these studies were instigating interventions which would be immediately effective and (in the short term) making efficiency savings in terms of workload. Both Barclay et al (2012) and Dykes (2005) suggest that structural constraints influence the context in which midwives interact with the women in their care. Due to organisational pressures, midwives process their work rapidly, efficiently and economically. Despite the importance of relationships for both midwives and service users, the

midwives sometimes conducted their work outside a relational context (Dykes, 2005, p249). Hunter (2006) explored reciprocity in her study exploring relationships between community-based midwives and mothers. Some encounters were experienced as balanced and emotionally rewarding where there was a feeling of give and take and reciprocity had developed over the course of a community-based relationship. These encounters were considered particularly important for facilitating authentic and trusting relationships.

The impact of comments and advice from health care professionals could be misconstrued and damaged women's confidence, leading some to question their ability to breastfeed. The ability to understand why healthcare professionals give the advice they do is central to understanding the perpetuation of variations in breastfeeding advice. The authoritarian way that health care practitioners communicate to women appears to worsen inconsistencies in advice and support that exist (Simmons, 2002). Practitioners were also reported in this study as leaving the women to seek help only if they felt they needed it, rather than proactive, anticipatory contact. I have explained earlier that such relationships are key to breastfeeding support. It is particularly interesting to note in Hunter's (2006) study a clear distinction between hospital and community environments, whereby the invisibility and impersonality of hospital encounters was contrasted with the recognition and reciprocity experienced in the community environment. In my study, it would appear that this is not the case for the women who participated. I could hypothesise that this may be due to a lack of continuity of carer due to the local reorganisation of community midwifery practice. Women need and want postnatal care and support that is individualised and meets their

specific needs (Hauck et al, 2002; Dykes et al, 2003; Sheehan et al, 2010).

Web-based advice resources have been argued to represent an arena in which mothers can enact various resistances to expert knowledge. Madge and O'Connor (2005) suggest the increased availability of online specialist advice/information provides a tool with which traditional modes of expert power can be contested and resisted. On-line parenting communities may also provide spaces for mothers to evade romanticised constructions of breastfeeding that are predominant in the current cultural context. In this study, anonymity in the online parenting discussions afforded women a transient break from the portrayal of the 'good' breastfeeding mother, and from the disparity between the idealised and lived realities of breastfeeding.

The next and final chapter of this thesis draws together and discusses the overarching findings from the three themes. Whilst all three themes stand alone they also contribute to an overarching general narrative which will be presented and then discussed in the next chapter. The implications of the study findings for health care professional practice are discussed, and suggestions for further research outlined.

CHAPTER 8

DISCUSSION AND CONCLUSIONS

8.1 INTRODUCTION

The previous three chapters presented the findings and interpretations from this study. This final chapter first of all locates these findings within the wider literature, focusing in particular on the extent to which the incongruity between expectations and experience had a negative impact, socio-cultural representations of breastfeeding mothers, and notions of expertise. This is followed by a personal reflection on the research journey, reflecting upon how the study was conducted. Thirdly, the strengths and limitations of the study are discussed. Finally conclusions and recommendations are made, in particular the implications of the study for health care professional practice and suggestions for further research.

8.2 THE PHENOMENON OF BREASTFEEDING – EXPECTATIONS AND SURVIVAL

As recognised by Greatrex-White (2004), it is sound phenomenological practice to provide a general account of how the phenomenon comes to exist. This section of the thesis is based on all the exemplars that have been discussed in the preceding three chapters of how breastfeeding comes to exist for all the participating women and this researcher. This global theme thus illustrates the overall phenomenon of breastfeeding.

The aim of the study was to explore the phenomenon of breastfeeding from the perspective of women who had initiated breastfeeding at the birth of their youngest baby. The emerging phenomena from the data were of 'expectations and survival'. Women had idealistic expectations of breastfeeding, but when they experienced the reality of breastfeeding in their own lives, in order to survive they had to find ways of managing the incessant demands and onus of responsibility for feeding their baby. They believed that health care professionals also had unrealistic expectations of how women should breastfeed. To survive these expectations, many of the women pretended to conform to the rigid targets and rules espoused, or to silently 'break the rules' imposed by the health care professionals. In addition to health care professionals, family, friends and society in general had varied expectations and prejudices about breastfeeding. To survive the scrutiny and contradictions of others, the women developed their own coping mechanisms. Each woman developed individual survival techniques according to their own and others' expectations and the demands of their baby.

8.3 DISCUSSION

The purpose of this study was to investigate the phenomenon of breastfeeding. A greater understanding of the phenomenon of breastfeeding from the perspective of those experiencing that phenomenon needs to influence practice, policy and research agendas. This study contributes to the evidence base following earlier criticisms that few studies had been undertaken since the increase in BFI accredited health services and BFI accredited pre and post registration health care professional training. Furthermore, participants have been recruited from a rural geographical area of the United Kingdom. Few studies have explored the experiences of women after the initial postnatal period: those who continue breastfeeding and those who discontinue. A diverse range of women were recruited to the study, with an array of backgrounds and infant feeding experiences. This study recruited 22 primiparous and multiparous women, of whom twelve were still breastfeeding at the time of data collection. Of the eight women interviewed when their youngest child was six months of age, three were exclusively breastfeeding.

The findings have been presented and interpreted in the previous three chapters. This study indicates complexities and diversities in the experience of breastfeeding. For all the women in this study breastfeeding was an unforgettable experience. For some, it had been '*horrible*' and '*traumatic*', a '*nightmare*', and they were unsure how they coped and fed for the length of time they maintained lactation. Others said their experiences were positive. One described breastfeeding as '*life sustaining and life changing*'. Not one of the participants described breastfeeding

ambivalently. The lack of positive experiences in the women's accounts of the phenomenon of breastfeeding is noticeable, although reflects the findings of previous research (Bailey et al, 2004; Dykes, 2002; Hoddinott et al, 2012; Redshaw and Henderson, 2012). The following discussion of the broader relevance of the findings is presented under three sub headings. These sub headings are direct quotations from the data that have been chosen as representations of the central issues to be explored.

8.3.1 '*I was meant to be able to do this*'

The concepts of unrealistic expectations, incessant demands and onus of responsibility in breastfeeding are not new. Whilst this has been discussed in previous literature, the extent of the shock of the reality of breastfeeding and impact of these feelings has not been documented. Thirteen of the women in this study described how their expectations of breastfeeding antenatally were different from their actual experiences. Their expectations and anticipation centred around breastfeeding being 'natural'. They expected breastfeeding to be intuitive, that both new mother and baby would instinctively know how to breastfeed when the baby was born. Shock was commonly used by the participants to express their reaction to breastfeeding. Only five of the women said they found breastfeeding easier than they had imagined, whereas seventeen made specific comments about how difficult breastfeeding was. They related stories of sleepless nights and an inability to do anything other than breastfeed. The women in this study discussed how a realistic picture of breastfeeding was unavailable from their antenatal preparation, social and cultural networks or various other types of media. Whilst the mismatch between expectations and experience has been identified in previous

research (Hoddinott et al, 2012; Redshaw and Henderson, 2012), this translated into an expectation of difficulties such as sore nipples, pain, fear of not producing enough milk and need for support. There is a wealth of literature describing guilt and despair when women's expectations based on the naturalness of breastfeeding, the desire to be a good mother, and 'breast is best' for baby clash with the demands and labour-intensive workload that breastfeeding entails (Burns et al, 2010; Hoddinott et al, 2012; Redshaw and Henderson, 2012). Both Hoddinott et al's (2012) serial interview study and Redshaw and Henderson's (2012) findings from a national survey suggested realistic antenatal education as key to prepare women for common difficulties. Participants in Hoddinott et al's (2012) study suggested needing a reality check rather than rosy pictures or patronising breastfeeding workshops with knitted breasts and dolls. Redshaw and Henderson's (2012) findings are based upon written responses to survey questions, although again participants described unrealistic information about breastfeeding in antenatal classes. Neither of these published studies however described as evocatively the extent of the impact of caring for a newborn baby whilst learning to breastfeed. One of my participants described her baby '*crunching*' at the breast, whilst others dreaded feeds and felt completely overwhelmed.

Becoming a mother forms a major transitional period in a new mother's life (Mercer, 2004). Previous work on the maternal transition has found that women were largely unprepared for their new role and identity. The early postpartum months have been described as a period of uncertainty and emotional precariousness (Nelson, 2003). Breastfeeding, and the pressure to do so, further compounds this transition. Findings from my study

provide new insights into how ill-equipped women are for breastfeeding, caring for a baby, and the change in themselves on becoming mothers.

8.3.2 *'I thought it would keep them all quiet'*

Findings from this study determined that women's breastfeeding behaviours were socially-mediated. Some felt coerced into initiating breastfeeding. They maintained their normative place as a good mother in society by attending outwardly to the good mother image by conforming to the moral obligation to breastfeed in the immediate period after their babies were born. Those women who had bought equipment for bottle feeding and formula milk powder prior to the baby's birth articulated a minimal intention to breastfeed, to *'do the right thing'*, but no intention to continue past the initial hospital and community postnatal care input. It appeared that it was more acceptable to fail to establish breastfeeding and then switch to formula, rather than make a choice to formula feed from the start. This finding builds upon notions of 'good mothering' in the wider literature. Feminist and sociological literature has explored the ways in which mothers negotiate issues of risk, deviance and morality in justifying their infant feeding practices (Murphy, 2000; Ryan et al, 2010). Murphy (2000) draws upon data from a longitudinal study of 36 mothers to describe how mothers defended their decision to switch to formula. Ryan et al (2010), using data from video interviews for a breastfeeding module (data analysed in relation to breastfeeding experience discussed in section 2.3 on page 54 of this thesis), analysed data that were coded as *'moral work'* (p953) to rationalise their infant feeding actions. Both of these studies identified the socio-cultural construction of the moral mother. Interpretation of data from my study adds to these understandings.

The women in this study articulated how they portrayed themselves as coping and in control, when in reality they were struggling and not enjoying their role as a breastfeeding mother. Whilst this finding has not been described in previous studies of breastfeeding, emotional control has been described in three published qualitative studies where participants were mothers with chronic illnesses (Gonzalez and Lengacher, 2007; Letourneau et al, 2007; Mitton et al, 2007). However, each of these studies reported different reasons for the emotional control demonstrated. Letourneau et al (2007) explored the support needs of 52 women with postnatal depression in Canada through individual and focus group interviews. Similar to findings from my study, the need to be perceived as the '*perfect mother*' (p445) motivated many of the women to mask or deny symptoms. As a result, they did not access and seek support. Gonzalez and Lengacher (2007) undertook an ethnographic approach using diaries as data collection tool. Over a six month period, eight breast cancer patients documented their thoughts and feelings in a diary. The mothers did not reveal their fears or intense emotions because they were concerned about the reactions of their family members. Again, those women who avoided sharing their feelings perceived themselves as not receiving the support they needed (p506). In contrast to these findings, Mitton et al's (2007) phenomenological study exploring the experiences of mothers with rheumatoid arthritis found that they put on a brave face and drew on their courage as a source of inner strength to deal with difficulties. In contrast to the findings from the study undertaken by Mitton et al (2007), analysis of the data from my study also showed that rather than be supported to overcome the challenges the women were experiencing with breastfeeding, and being helped to develop a peer support network, the women's social withdrawal (in not attending postnatal support groups or baby clinics) further perpetuated this. Not only did the women in my study feel they

should be able to cope with breastfeeding, but they also felt they were responsible for continuing to undertake domestic duties. Research suggests that this reflects cultural representations of 'superwoman', who is able to juggle any number of competing demands (Ussher et al, 2000).

Some of the women prioritised their own needs and the family unit over baby-centred exclusive breastfeeding. Maintaining an illusion of compliance, seven participants described acts of subversion in which they did not adhere strictly to the breastfeeding guidance and advice provided by health care professionals, which they viewed as intransigent. They articulated the ways in which they ignored or dismissed advice from health care professionals, for example with regards to supplementary feeding. These decisions were justified as pragmatic approaches to infant feeding that met not only the baby's needs but also their own and those of the whole family. Physical and emotional support for exclusive breastfeeding from family and friends was lacking. In combination with the rigid and inflexible approach to breastfeeding espoused by health care professionals, exclusive breastfeeding was perceived as an inconvenience, an additional burden that did not fit with family life and was therefore an unrealistic and unattainable ideal. Few of the women in this study had family members who had experience of breastfeeding, or family members who had breastfed for more than the first few days. These family members actively discouraged the women from continuing with breastfeeding, as described by Michelle, Nicola and Octavia. There are similarities between these findings and those published by Lavender et al (2006) in which family members, despite expressing their support for the breastfeeding woman, appeared to be overtly or covertly undermining breastfeeding. Lavender's participants cited examples where family members went out so that the

woman could breastfeed in peace and quiet. The women felt isolated and marginalised. This was further compounded, the authors suggest, by the women's inability to articulate what they felt was conducive support. Women were victims of their own portrayed success. Pretending to be coping, as some of the women in my study described, denied them offers of practical help. Whereas family members did not have experience of breastfeeding to pass on, practical help with childcare, home duties, meal preparation, would have been appreciated and conducive to supporting breastfeeding continuation.

The women in this study were covert in their management of infant feeding. They did not volunteer their infant feeding decisions and behaviours to health care professionals for fear of reprisals. These findings exemplify the women devising strategies in order to overcome their difficulties and barriers with breastfeeding, and also to regain control over infant feeding decision-making. Introducing occasional formula feeds was conceptualised as a control put on breastfeeding in an attempt by women to return to normal. Similar interpretations were reported by Johnson et al (2009) who analysed video and interview data from first time mothers' accounts of infant feeding. Using a feminist perspective to underpin their analysis, expressing breast milk was constructed as a *'route to freedom and a way of coping with the demands of breastfeeding'* (p905). In doing this, the women were demonstrating agency in their infant feeding management, resisting the moral expectations of the good mother who places her baby's health and welfare above all else. The explanation given by participants in my study for not disclosing their infant feeding behaviours differs from the recently published paper by Hoddinott and colleagues (2012), who suggested the reported duplicity in infant feeding

behaviour reflects complexities and ambiguities in feeding advice from health care professionals. Hoddinott et al (2012) suggested that there was lack of clarity from evidence-based guidelines ranging from exclusive breastfeeding for six months, breastfeeding for six months is ideal, and any breast milk is better than none (p10). The research evidence and rationale behind many of the 'rules' espoused by health care professionals was therefore unclear to parents. The women in my study presented their subversive infant feeding management not as personal choice but in acquiescence to the health and wellbeing of the family unit.

Fear of sanctions or criticism from health care professionals seems to inhibit women from seeking help or being honest about infant feeding management and plans. This seems to relate to infant feeding communication being presented by health care professionals as a dichotomy – breast or formula. Coupled with the prevailing public health messages extolling the virtues of breastfeeding, anything other than exclusive breastfeeding was perceived as deviant. The experience of participants was that health care professionals were not necessarily judgemental if women did not breastfeed exclusively. Nevertheless, the women's perceptions were that they would be. In Lee's (2007) study about mothers' experiences of using formula milk for infant feeding, participants admitted lying about their infant feeding behaviour to health care practitioners, giving examples of hiding formula milk and bottles. Her participants expressed guilt and failure associated with 'risky feeding' (p304). More experienced mothers expressed anger and defiance. This has received sparse attention in the published literature on the phenomenon of breastfeeding, yet has profound implications for clinical practice.

8.3.3 *'You feel like you're being checked up on...you're kinda passing a test'*

The majority of mothers in this study expressed feeling pressured, judged and scrutinised regarding breastfeeding. These findings lend support to arguments that health care professionals are becoming the primary authorities and moral gatekeepers of contemporary infant feeding. High breastfeeding initiation rates may therefore be a reflection of compliance with cultural expectations towards breastfeeding. However, the rapid drop in breastfeeding rates in the early postnatal period highlights a dissonance between women's needs and healthcare professional practice in supporting breastfeeding women. Supplementation with formula milk, and emphasis on precise amounts, timings and frequent weight reviews described by the participants in this study reflects a biomedical paradigm of clinical breastfeeding support.

A significant finding is the problem of feeling pressured to perform or judged (to demonstrate capability as a breastfeeding mother, verified by adequate weight gain) by health care professionals. Considerable efforts have been invested in attempting to change attitudes and behaviours amongst health care professionals that were counter to the promotion of breastfeeding. Throughout the period of data collection for this study, specific efforts were being made within the local hospitals with regards to adherence to UNICEF Baby Friendly Hospital Initiative (BFHI) *'Ten steps to successful breastfeeding'* (WHO, 1998), including provision of education in supporting breastfeeding for staff in their drive to gaining stage 2 accreditation. However, the findings from this study indicate failings in professional support for breastfeeding. Women described a model of

support that was reactive to requests for help rather than proactive. The help they did receive was described by many of the women as rigid and dogmatic, driven by targets and rules, rather than being woman-centred, flexible, and based upon the woman's individual needs. Multiparous women felt their needs were neglected and overlooked. Online discussion groups were accessed by two of the women who valued the 24-hour availability offered, but also the degree of anonymity it afforded, which they felt was conducive to openness and candour amongst the discussion group members. It is unlikely that the negative experiences of support from health care professionals described by the women in my study are unique.

The focus of health care professional practice appears to be on reinforcing the notion of expertise, rigidly attending to the '*Ten steps to successful breastfeeding*' (WHO, 1998), and the widespread acceptance of BFHI as a panacea to the poor rates of exclusive breastfeeding in the United Kingdom. Mothers reported uncertainty over the 'rules' and rationale behind the breastfeeding practices they were taught, for example the step-by-step approach to positioning and attachment, being shown how to hand express prior to discharge home from the postnatal ward, but at the same time being informed that expressing breast milk before 8-12 weeks was discouraged, use of nipple shields, and that bottles and teats would confuse the breastfed baby. The women in this study described a tick box approach to breastfeeding practice in which women received care and advice that was prescribed and standardised, rather than individualised and woman-centred. Midwifery practice in particular would seem confined in response to meeting guidelines such as NICE (2006), BFI accreditation and standards defined by the Clinical Negligence Scheme for Trusts (NHS Litigation Authority, 2012).

Findings from this study indicate failings in professional support for breastfeeding. Midwifery in the UK has become increasingly professionalised, institutionalised and medicalised (Kirkham, 2010; van Teijlingen, 2005). This body of work shows that notions of power, expertise and medicalisation affect the quality of relationships between midwives, medical professionals and women in maternity care. Central to the debate about where the role of health care professionals are positioned in the provision of infant feeding care (mirroring older debates on the medicalisation of pregnancy and childbirth) is the question of whether or not breastfeeding is a normal physiological process. Ivan Illich used the term iatrogenesis for the harmful epidemic of disabling medical control. Illich (1976) argues that there is no proven benefit of many medical interventions, and thus no proven causal link between increased medicalisation and improved outcomes. I would suggest that this applies to breastfeeding – increased medicalisation and technological approaches by health care professionals has not resulted in increased breastfeeding duration. Dykes (2006) argues that there is a risk in merely changing one dominant culture (medicalisation) for another (rigid implementation of UNICEF standards), without addressing the constraints that are placed upon either the midwives or the women to maintain breastfeeding in contemporary society. The monopoly of the BFHI in promoting and supporting breastfeeding would seem to be preventing the investigation of new and innovative approaches to breastfeeding promotion and support. Undoubtedly the BFHI has improved certain aspects of postnatal care such as separation of mother and newborn baby. However, adherence to the *'Ten steps to successful breastfeeding'* (WHO, 1998) translated into a mechanistic technique for 'correct' positioning and attachment, rules including when women can express, and a ban on the use of bottles and teats for fear of confusing the baby. Some of the women in my study felt

they were either passing or failing, and this led to reduced self confidence and reduced self responsibility. The women in my study who felt they were successful in attaining their breastfeeding goals were different in their attitudes towards breastfeeding management and ownership of breastfeeding. These women placed value on their own expertise and confidence rather than unquestioning deferment to professionals. Increased dependency upon the advice and assistance of health care professionals undermines women's confidence in their own embodied knowledge. Consistent with Illich's (1977) disabling professions, it is argued that the medical model forced women into a submissive and passive role in which science and technology dominate over women's trust in their own bodies. Midwifery was ideologically opposed to this obstetric, medically-dominated model of childbirth. However, it would seem as though in relation to the provision of care for breastfeeding women, the philosophy of midwifery, to be 'with woman' has been compromised.

The women in my study identified that developing a rapport was important for effective care. The women ascribed inconsistencies in advice with breastfeeding to the lack of continuity in carer. Data collection was undertaken when the women's youngest baby was between three and six months of age. At that point in time, every family should have been in receipt of 'universal' health visiting services as part of the Healthy Child Programme for under 5's (Department of Health and Department for Children, Schools and Families, 2009). However, only one woman interviewed knew the name of her health visitor. Effective interpersonal skills, language and reciprocity were highlighted in a qualitative study of women's experiences and expectations of in-patient postnatal care as contributing to enhancing women's confidence in care givers (Beake et al,

2010). As highlighted by Edwards (2010, p99), without developing a relationship and therefore understanding of the individual woman, communication can become 'formulaic' and not necessarily sensitive to the individual woman's needs. The women in my study repeatedly described formulaic step-by-step, rigid care encounters in their recollections. Furber and Thomson's (2010) grounded theory study exploring midwives' use of language identified that midwives presented breastfeeding information in a way that minimised discussion and debate. In this way, the midwives were exercising power over the women to ensure that they breastfed.

One of the significant factors identified by participants was that midwives were too busy to provide breastfeeding care and support, particularly on the postnatal hospital ward. Staff shortages and lack of staff time is a dominant theme in much of the research concerning postnatal care (Beake et al, 2010; Dykes, 2009; Furber and Thomson, 2010). Women recognised this and were reluctant to ask for help. They did not blame individual staff but the context and organisation of postnatal care. It could be suggested that the 'hands-on' approach to positioning and attaching baby to the breast the women in my study described receiving, and disliked so vehemently, was a response to the limited time available for midwives to complete tasks.

Hunter (2011) has highlighted conflicts between midwives working '*with women*' (providing individualised care), and '*working with the institution*' (meeting the demands of the employing organisation in activity and productivity). She notes from her fieldwork that she was disappointed with the quality of communication between midwives and women, noting many

closed questions and leading questions, and missed opportunities for interaction. However, as she became immersed in the field, she became aware that the midwives' communication styles were strategies for managing these conflicting demands rather than poor practice (Hunter, 2011, p171). Hunter's findings were that whilst midwives held a strong ideal of practising 'with woman'; in reality their focus had to conform to task completion, 'with institution'. This is an important finding that has implications in terms of unmet needs.

It could be argued that few of these findings and interpretations are new. They resonate with findings from other studies into the phenomenon of breastfeeding published over the past decade. However, it appears that policy and practice are not taking these into account. Listening and learning from real women's experiences in Taylor and Hutchings' (2012) study drew attention to the stark reality when midwife participants realised they had lost sight of what women want.

8.4 UNIQUE CONTRIBUTION TO KNOWLEDGE

This study contributes to knowledge through the following:

- The extent to which inadequate preparation for breastfeeding had a negative impact on the breastfeeding experiences of women in this study was a surprise. Findings from this study indicate a gap surrounding a lack of understanding and preparation for common problems, and a lack of

awareness of newborn behaviour. Misunderstandings of newborn behaviour resulted in the women blaming infant feeding behaviours such as crying, wakeful states and cluster feeding, on the specific method of infant feeding. There was a drive in the women's descriptions to establish routine and predictable feeding and sleep patterns. Frequent feeding cues were overwhelming and the women felt overawed by the sense of responsibility. It also led them to question their ability to provide an adequate milk supply.

- This study builds on understandings of 'good mothering' in the wider literature. Women's breastfeeding behaviours were socially-mediated. Some felt coerced into initiating breastfeeding. They maintained their normative place as a good mother in society by attending outwardly to the good mother image by conforming to the moral obligation to breastfeed in the immediate period after their babies were born. Those women who had bought equipment for bottle feeding and formula milk powder prior to the baby's birth articulated a minimal intention to breastfeed, but no intention to continue past the initial hospital and community postnatal care input. It appeared that it was more acceptable to fail to establish breastfeeding and then switch to formula, rather than make a choice to formula feed from the start.
- This study has provided insights into women's infant feeding decisions and behaviours. The women presented their covert management of infant feeding in acquiescence to the whole family unit, rather than exclusive breastfeeding which was perceived to be baby-centric. However, they were discreet about this for fear of sanctions or criticism from health care

professionals. The experience of participants was that health care professionals were not necessarily judgemental if women did not breastfeed exclusively. Nevertheless, the women's perceptions were that they would be. This has received sparse attention in the published literature on the phenomenon of breastfeeding, yet has profound implications for clinical practice.

- This study highlights the previously unknown strategies that women employed to portray themselves as calm, coping and in control when in reality they were struggling and not enjoying breastfeeding. The need to be perceived as the perfect mother motivated women to mask their true feelings. As a result, the women did not access or seek support. They also withdrew socially (in not attending postnatal groups), which perpetuated the challenges breastfeeding brings. This is not a finding that has received attention in published breastfeeding studies to date.
- This study highlights failings in professional support for breastfeeding. The women described feeling pressured to perform and judged by health care professionals (to demonstrate capability at breastfeeding, verified by adequate weight gain). Support for breastfeeding was reactive to requests, dogmatic, and rigid. Multiparous women felt overlooked. The lack of support for exclusive breastfeeding after the initial postnatal period in particular has received sparse attention in the published literature. Links have been drawn here to Ivan Illich's notion of iatrogenesis– increased medicalisation and technological approaches by health care professionals has not resulted in increased breastfeeding duration. Increased dependency upon the advice and assistance of health care professionals

undermines women's confidence in their own embodied knowledge.

Consistent with Illich's (1977) disabling professions, it is argued that the medical model forced women into a submissive and passive role in which science and technology dominate over women's trust in their own bodies.

- A significant finding is the use of online discussion forums. In this study, anonymity in the online parenting discussions afforded women a transient break from the portrayal of the 'good' breastfeeding mother, and from the disparity between the idealised and lived realities of breastfeeding. This could be exploited in terms of potential development of social media support for breastfeeding.

8.5 REFLECTING ON THE RESEARCH JOURNEY

Conducting this qualitative study has been both challenging and rewarding. Taking the opportunity to reflect on how the study was conducted provides me with the opportunity to consider how I could have done things differently, and what I would take forward into any future research endeavours. The challenges I faced related primarily to the adoption of a suitable methodology for the project and the conduct of this research on a part-time basis. Like many other mature students, I am a wife, a daughter, a colleague, a friend, but also, and of importance to my research, a mother to three children. Reflecting back as thesis writing neared completion, I realised that, having commenced the doctorate programme on my return from maternity leave, my youngest daughter had never been on holiday without me writing an essay, research proposal or draft thesis chapters.

The role of researcher was a role I had taken on previously to commencing the doctorate, through using questionnaires on an action research project, and interviews to gather data for my Master's degree study. Overall I felt comfortable with the role of researcher; however this research study has involved a steep and at times tortuous journey, as I have developed my understanding, appreciation and skills at both undertaking research, interpreting the published work of others, and negotiating access to potential participants through the NHS Trust research governance framework. My research diary has been invaluable in allowing me to reflect on this journey. Through my diary entries I can see how I grew in confidence and skill at being the interviewer. The third interview [Charlotte] reflected afterwards in the diary an excitement I felt:

Fab interview. Hope it carries on like this. She had so much to say, a range of experience - overwhelming joy, profound disappointment and grief. I could really make a difference if these voices get heard
[Diary p38]

Not all of the interviews were as successful. In particular the interview with Tanya:

Struggled to get more than monosyllabic answers. Felt as if she had rehearsed what to say before I got there. Why did she contact me to take part if she didn't actually want to 'take part'?? [Diary p162]

Phenomenology as a methodology and as underpinning principles for the study methods was also a daunting part of the learning process. I had no previous experience of conducting interpretive analysis. NVivo version 7 was used to aid the storage and retrieval of data, for recording memos, and also for making links between sections of data, but access to this programme was only achieved once 13 interviews had been conducted, so both the manual printing and sorting method was undertaken, using highlighter pens, several copies of the transcripts on different coloured paper for each transcript, envelopes and scissors, in addition to NVivo. Whilst this might appear to be duplicating effort somewhat, it provided me with an opportunity for reading and re-reading the data and developing an intimacy that might not have been achieved otherwise.

8.6 STRENGTHS AND LIMITATIONS OF THE STUDY

There are strengths and limitations to most studies. The study presents interpretations of the phenomenon of breastfeeding as experienced by a small number of women from one city in the East Midlands. These data may not be generalisable to the whole of the UK, however findings resonate with those of other studies. The interviews were undertaken between three and six months after the birth of the youngest baby, which may have affected some women's ability to recall infant feeding experiences (although a review of 11 published studies has shown maternal recall of breast-feeding initiation and duration to be reliable and valid, especially when the duration of breastfeeding is recalled after a short period (≤ 3 years) (Li et al, 2005). It is however hoped that this negated a

Hawthorne effect whereby the women may have been motivated to continue breastfeeding due to the interest being shown in them as participants in the research study.

There was a limitation in the demography of the participants. Only one non-white British woman was recruited to the study. People from ethnic minority groups were not excluded from the study but their absence is a reflection that all the recruitment material was provided in English and that resources did not allow for bilingual researchers or translation of materials.

The women self-selected to participate in this study. They may have had overt opinions, or an axe to grind about services received. However, during the recruitment stage efforts were made to negate these potential limitations by informing potential participants and health visitor recruiters that the inclusion criteria was breastfeeding for the first two weeks, and that it was my hope to recruit a broad spectrum of participants with a range of infant feeding experiences. I was mindful that if I had collected the data during the early postnatal period, women may have been reluctant to criticise aspects of care and more likely to express satisfaction. I assured participants that I was not an employee of the hospital or community Trust and that participation in the research study would have no bearing on their subsequent care. Gathering data between three and six months after the baby's birth provided some time distance from the relatively intense and frequent care received in the earlier postnatal period. It was hoped that this would provide participants with an opportunity to be honest and authentic in their responses about what was important to them.

The phenomenological approach provided an opportunity to gain insights into the experiences of primiparous and multiparous women. All the participants in this study initiated breastfeeding; some were still exclusively breastfeeding at six months, some of them stopped after two weeks. To ensure the rigour of this research study an intimate relationship between the researcher's interpretation and the data revealed by the women's experiences was maintained throughout the study, and was preserved by continuously revisiting the interview transcripts during the analysis and writing of this thesis. Direct quotations from the participants throughout the findings chapters contribute to supporting the arguments. In addition to providing empirical data to support the conclusions made, the extensive use of quotations provides a means of giving women a voice.

8.7 CONCLUSIONS

The findings offer insight into women's lived experiences of breastfeeding. It could be argued that few of these findings and interpretations are new. However, it appears that policy and practice are not taking these into account.

Exploring the phenomenon of breastfeeding through the experiences of a range of women who used diverse feeding practice, rather than exclusively and solely breastfeeding, allows an understanding of the phenomenon of breastfeeding and the influences on women's infant feeding decision-making and behaviours. The evidence clearly shows the phenomenon of

breastfeeding to be both complex and diverse. For all the women in this study breastfeeding was an unforgettable experience.

This study makes a significant contribution to the existing literature. This study illustrates how women manage infant feeding behaviours in order to prioritise the health and wellbeing of the family unit over baby-centric exclusive breastfeeding practices. The study also illustrates how women reposition themselves in order to influence moral judgement over their infant feeding behaviours.

Women need to make true informed choices regarding infant feeding. It was clear from this study that some women felt coerced into initiating breastfeeding, and whilst some of these subsequently continued breastfeeding out of their own choice, many had no intention to continue and preferred to be perceived as failing at breastfeeding rather than choosing to formula feed.

Health care professional practice in relation to infant feeding needs to change. I have argued that health care practice reported by the women in this study mirrors the medical model that privileges professional knowledge and power. Under this model, women assume a submissive and passive role. This is considered anathema to a midwifery philosophy. Increasing breastfeeding duration hinges on realistic expectations of breastfeeding. It is not suffice to overwhelm women with an increasing list of health benefits of breastfeeding, particularly given that the evidence is weak or inconclusive for many of those widely cited. Health care

practitioner support for breastfeeding should not be restricted to a rigid and dogmatic adherence to prescribed 'rules'. Support needs to be individualised, woman-centred, facilitative and based on partnership. Consideration should be given to increasing the length of time home visiting is offered to women in support of breastfeeding continuation. Health care practitioners also need to provide women with the space and confidence to find their own way for breastfeeding to be, not the step-by-step, painting by numbers approach described by many of the women in this study.

Integrating breastfeeding into normal, everyday family life encompasses both public and private spheres, in addition to the women needing to establish their own breastfeeding culture and support network.

The summary of the findings of this study represents the phenomenological interpretation of the experience. This is the interpretation of the phenomenon developed from an understanding of the perspective of women who have breastfed obtained through phenomenological enquiry. The fundamental structure of breastfeeding obtained in this study can be described as:

Women were ill-prepared for the realities of breastfeeding and for most women the shock of this experience was overwhelming. They found the demands and onus of responsibility for their newborn infant to be incessant. Initiating breastfeeding was found to be a

task to be mastered and accomplished, but the support for breastfeeding from health care professionals was inadequate and at times inappropriate. Women maintained their place in society by attending outwardly to the good mother image by conforming to the moral obligation to breastfeed in the immediate period after their babies were born. However, knowledge of the health benefits of breastfeeding was not a motivator to continue exclusive breastfeeding past the initial postnatal stage. Some women maintained a public pretence in relation to how they themselves were feeling about breastfeeding, maintaining an outward appearance of calmness and control, hiding the difficulties and struggles they were experiencing with breastfeeding. The experience of breastfeeding is influenced by conflicting viewpoints of breasts as sexualised and nurturing, relational components of breastfeeding versus a medicalised approach, images of breastfeeding in terms of the age of the infant, and perceptions of breastfeeding in shared public spaces.

8.8 RECOMMENDATIONS FOR CLINICAL PRACTICE

- Antenatal education should focus more on preparing women for the realities of breastfeeding their newborn, rather than an idealised version.
- Women need to be able to make informed choices regarding infant feeding, from initiation and throughout their infant's life. Health care professionals need to work in partnership with women and their families to facilitate this decision-making, regardless of feeding method chosen.
- Midwives should explore the earlier infant feeding experiences of multiparous pregnant women in order to be aware of previous experiences that may influence perceptions of breastfeeding subsequent babies.
- There is a need to emphasise communication skills and techniques, and relationship building, in breastfeeding training in addition to teaching positioning and attachment.
- It is of paramount importance that a no-touch technique is used in facilitating women to learn how to position and attach their baby at the breast.

- An aspect of breastfeeding support in the immediate postnatal period that would be appreciated by women is the provision of a health care professional sitting through a complete breast feed. This would provide an opportunity not only to advise on positioning and attachment, but also infant feeding cues and infant behaviours, using the time as an opportunity to talk with the woman about her expectations, support network and perceptions of infant behaviour.
- Time and workload pressures on midwives and the organisation of postnatal care, both in hospital and in the community, needs to be addressed. Breastfeeding support should be proactive rather than reactive to requests for help.
- Midwives and health visitors need to embrace technology and social media in order to support breastfeeding women, for example websites, Smartphone applications (apps), Facebook, podcasts, videos, twitter, helplines and proactive text-messaging.
- Midwives and health visitors must emphasise care of the mother as much as care of the baby.
- Health care professionals need to be aware of impression management. Women need to take care of themselves and be encouraged to prioritise and verbalise their own needs, for example for practical help with childcare, home duties, and meal preparation.

- Encouragement of attendance at breastfeeding group from discharge home in order to facilitate earlier establishment of peer support / social network.
- There is a need to develop a family-centred approach to infant feeding.
- Increased home visiting for breastfeeding mothers from midwives and health visitors over the medium to long term.
- Public health interventions to promote positive attitudes to breastfeeding need to be developed and evaluated.

8.9 RECOMMENDATIONS FOR FUTURE RESEARCH

- An exploration of the language and practices used by health care practitioners, in particular midwives and health visitors, when supporting breastfeeding women.
- An exploration of the impact of the BFHI standards on health care professionals.
- An exploration of the effectiveness and acceptability of social media support for infant feeding.
- Future infant feeding studies in Lincolnshire should purposively sample Portuguese, Polish, Latvian and Lithuanian women and their families to reflect the ethnic diversity of this County.

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APPENDICES

APPENDIX 1: The Ten Steps to Successful Breastfeeding**The Ten Steps to Successful Breastfeeding**

(WHO, 1998, p5)

Every facility providing maternity services and care for newborn infants should:

1. Have a written breastfeeding policy that is routinely communicated to all health care staff.
2. Train all health care staff in skills necessary to implement this policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within a half-hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breastmilk, unless *medically* indicated.
7. Practice rooming-in - allow mothers and infants to remain together - 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

APPENDIX 2: The Seven Point Plan for Sustaining Breastfeeding in the Community

The Seven Point Plan for Sustaining Breastfeeding in the Community

(UNICEF UK Baby Friendly Initiative, 2008)

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all staff in the skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding, with appropriately-timed introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote co-operation between healthcare staff, breastfeeding support groups and local community.

APPENDIX 3

Studies included in the literature search on UK women's breastfeeding experiences (Section 2.3)

Author	Methods	Participants	Results	Strengths and Limitations
Bailey et al (2004)	Qualitative interviews	16 women, who expressed an intention to breast feed, at 37 weeks in their pregnancy and again at 3–9 weeks postnatally	Decisions about breast-feeding cessation were usually made within the first few days. A 'give it a go' breast-feeding culture was identified, where women who intended to breast feed had a strong expectation of difficulties and even failure.	Small sample size. However, detailed exposition of methods and process of data analysis. Ethical approval received. Data analysis underpinned by grounded theory, iterative, taking place concurrently with data collection. Sample of interviews subjected to cross-researcher checking by all members of the research team. Findings presented to community midwifery team meeting, and their feedback taken into account in the findings and conclusions.
Bailey (2007)	Qualitative-semi-structured interviews	Convenience sample of 6 women and 5 men. The women were either	Six major themes: the woman is most affected by the decision to breast feed; infant feeding as a practical issue and therefore the decision to return to work is	Convenience sample from friends and family. Author stated it was thought valuable that the father was able to bottle-feed the baby. However, it was not stated whether this was a

		breastfeeding, combination feeding or had recently weaned.	linked to bottle feeding; the participants felt it was valuable for fathers to have the opportunity to bottle feed their infant; breastfeeding was considered natural; formula milk was perceived as contributing to healthy weight gain and that breast milk was not sufficient in this regard. Confidence and determination was deemed necessary for continued breastfeeding.	bottle of formula or expressed breastmilk. In the discussion section, Bailey linked this to Gabrielle Palmer's (1993) assertion that men can feel jealous because they cannot breastfeed and feel excluded, but then stated that none of the men in her sample gave that impression (2007, p152). Ethics approval received. Data analysis process (IPA) briefly stated. Reflexivity not apparent.
Choudhry and Wallace (2010)	Descriptive qualitative study using structured items assessing acculturation status and open-ended questions forming a	20 South Asian women either pregnant or with a child under the age of five.	Women displaying low acculturation levels were aware of living in a formula-feeding culture but this had little influence on breastfeeding intentions/behaviours; drawing upon South Asian cultural teachings of the psychological benefits of breast milk. These women opted to formula-feed in response to their child's perceived	First study in UK to explore acculturation status in women born in the UK as well as those who had immigrated to the UK from South Asia. Convenience sample. Bangladeshi women not included due to researcher's inability to speak or understand Bengali. Reliability and validity of acculturation scale derived from studies of Hispanic and Latino immigrants in USA. Ethics approval

	semi-structured interview.		demands or in a bid to resolve conflict; either when receiving information about the best feeding method or between their roles as a mother and daughter-in-law. Highly acculturated women also experienced such conflict; their awareness of the formula-feeding culture governed feeding choice.	received. Reflexivity not apparent. Caution re accuracy of recall of breastfeeding experiences > 3 years.
Dykes (2005)	Qualitative, ethnographic study based on observation and interviews	61 women in a postnatal ward setting (40 primiparous, 21 multiparous women)	Breastfeeding conceptualised as a 'productive' project: providing, supplying, demanding and controlling.	Consultant-led maternity units in North of England – not BFI accredited. Clear exposition of ethical issues, methodology and methods. Reflexivity apparent. Note that study encompasses the first few days postnatally – not established breastfeeding experience. Possibility of Hawthorne effect on midwifery practice acknowledged.

Dykes et al (2003)	Focus groups and in-depth semi-structured interviews	7 participants aged 16 to 19 years	Five themes identified: feeling watched and judged, lacking confidence, tiredness, discomfort and sharing accountability.	Clear exposition of ethical issues, methodology and methods. Rigour and credibility addressed. Reflexivity apparent. Whilst the study sampled both primiparous and multiparous adolescents, only one multiparous adolescent took part in the focus group interviews, and only one other multiparous mother took part in the interview phase. The authors took explicit care to ensure that the data generated by these two mothers did not skew the development of themes. However, their experiences and support needs were "broadly similar" (p398). Whilst the data may have some applicability to breastfeeding mothers across age groups, the themes seem particularly relevant to adolescents.
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Gatrell (2007)	Qualitative, in-depth interviews	20 women who returned to employment within 1 year of childbirth	Breastfeeding was viewed as 'taboo' in the workplace. Mothers were therefore obliged to cease breastfeeding or conceal breastfeeding activities.	Limited description of underpinning methodology and process of data analysis. Ethical issues not addressed. Reflexivity not apparent.
Hoddinott et al (2012)	Qualitative, serial interviews every four weeks from late pregnancy to six months postnatal. Face-to-face interviews during pregnancy, within 4 weeks of birth and at 6 months. Shorter, mostly telephone, interviews (0–	36 primiparous and multiparous women, 26 partners, eight maternal mothers, one sister and two health professionals.	The overarching theme was a clash between overt or covert infant feeding idealism and the reality experienced. Pivotal points where families perceived that the only solution that would restore family well-being was to stop breast feeding or introduce solids. Immediate family well-being was the overriding goal rather than theoretical longer term health benefits. Feeding education was perceived as unrealistic, overly technical and rules based.	Clear exposition of methods, sampling strategy, data collection and analysis. Ethical approval received. Serial qualitative interviews were chosen as trust can develop between the researcher and participant, thereby facilitating in depth exploration of how perspectives, experiences, relationships and behaviour change over time. Multi-disciplinary research team with infant feeding research experience from different backgrounds: nutrition; the voluntary sector; social policy; midwifery and general practice – to minimise bias and researcher assumptions. However, potential influence of being part of a serial interview study on

	5) in between.			infant feeding decisions and practices. It is also likely that the women who volunteered were among the more advantaged living in disadvantaged areas. Women were recruited to the study via a letter on maternity unit headed paper, which may have influenced data collected on health professional influences.
Marshall et al (2007)	Qualitative study included observation in a community setting and in-depth interviews	158 interactions between breastfeeding women and midwives or health visitors, plus in-depth interviews with sub sample of 22 women and 18 health professionals	Questioned the value attached to breastfeeding as synonymous with being a 'good mother' in the social and structural context of the women's lives.	Clear exposition of methods, data collection and analysis. Ethical approval received. Reflexivity apparent. Health professionals acted as gatekeepers – for example not facilitating access to teenage mothers. Researcher introduced as a midwife, which may have identified her with the health professionals making the introductions.
Redshaw and	National survey of women's	534 responses relating to infant	The main themes identified were 'the mismatch between women's	Clear exposition of methods, data collection and analysis. Ethical

Henderson (2012)	experience of maternity care in England. Qualitative analysis of open text responses to two open questions.	feeding from 2966 multiparous and primiparous women, 3 months after giving birth	expectations and experiences' and 'emotional reactions' at this time, 'staff behaviour and attitudes,' and 'the organization of care and facilities.' Subthemes related to seeking help, conflicting advice, pressure to breastfeed, the nature of interactions with staff, and a lack of respect for women's choices, wishes, previous experience, and knowledge.	approval received. Reflexivity apparent. Analysis of data from feeding-related responses. Unable to probe responses to explore issues raised, although women may have been more forthright and honest in their responses. Respondents self-selected and were more likely to be older, educated and of white ethnicity than women who did not respond.
Ryan et al (2011)	Qualitative, in-depth interviews	49 women who were breastfeeding or had done so in the previous two years	Three central, iterative dimensions: calling, permission, and fulfilment. 'Calling' is characterised as nonverbal communication between mother and baby, the woman's body knew and acted immediately and intimately before she had time to reflect. 'Permission' refers to the uninterrupted and protected space in which breastfeeding takes place and the women	Clear exposition of methods, data collection and analysis. Ethical approval received. Participants were recruited to achieve a maximum variation sample on the basis of age, education, ethnicity, region, parity and breastfeeding duration. Phenomenological interpretation of women's narratives incorporated physical and discursive elements of lived experience. Trustworthiness of data assessed by project advisory

			described 'fulfilment' in terms of the closeness, comfort, and bodily compatibility of successful breastfeeding.	group of experts and key stakeholders.
Thomson and Dykes (2011)	Qualitative semi-structured interviews.	15 women who had a baby under 12 months of age.	<p>Part of an evaluation study of the implementation of the UNICEF UK BFI Community Award within two primary (community-based) care trusts.</p> <p>Women's experiences of infant feeding were influenced by the 'comprehensibility' (how or what information health professionals provided to women, a need for consistency, and choices around breast or formula feeding); 'manageability' (influence of the birth experience, manhandling of women's breasts, personal support systems, the value of time, accessibility of support and benefits and barriers to peer support) and 'meaningfulness'</p>	Small cohort of women from one geographical area. Clear exposition of ethical issues and methods, including sampling strategy and data analysis.

			(encouraging and not dissuading, theoretical vs. embodied knowledge, media messages and public breastfeeding, and emotionality of infant feeding) of this life event.	
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APPENDIX 4

Letter of invitation to participants

Version 2: 5th November 2008

Dear Madam,

**An exploration of the breastfeeding experiences of women in one
East Midlands city.**

I am currently studying for a Doctorate in Health Sciences which is being undertaken at the University of Nottingham, and as part of this course I am undertaking a research study.

I would therefore be extremely grateful if you would be so kind as to take a few minutes to read the accompanying participant information sheet and consider whether you are willing to take part in the study.

It is intended that the completed research study will contribute to understanding the experience of infant feeding, and factors influencing infant feeding decisions, in addition to being submitted as a dissertation and for publication in a relevant peer-reviewed journal.

With grateful thanks,

Rachael Spencer
RGN RHV RNT BSc (Hons) MSc
Senior Lecturer in Nursing
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APPENDIX 5

Participant Information Sheet
Version 2: 5th November 2008

Study title: An exploration of the breastfeeding experiences of women in one East Midlands city.

Before you decide whether to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and if there is anything that you are unsure about, please contact me for further information.

What is the purpose of the study?

The study is being conducted for a Doctorate in Health Sciences which is being undertaken at the University of Nottingham. I am employed at the University of Lincoln as a Senior Lecturer in Nursing, and am also a qualified nurse and health visitor.

Many studies have been undertaken that identify decisions made regarding infant feeding methods at birth, particularly in relation to infant health and development, maternal health, and attachment between mother and infant. However, there is a relative lack of published research into women's perceptions of infant feeding. Of the studies that have been undertaken, these are predominately survey studies of attitudes or studies surrounding infant feeding decisions at birth, which provide data related to the mother's age, ethnicity and employment status, but very little in-depth knowledge. It is vital to gain an understanding of the experience of infant feeding, and factors influencing infant feeding decisions.

Why have I been chosen?

You have been selected for inclusion in this study because you breastfed your child at birth and were still breastfeeding at the Health Visitor's first visit. If you are prepared to be interviewed as a study participant, please contact me directly (by any medium) to arrange a mutually suitable date, time and place to conduct the proposed interview.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision not to participate will not affect your care in any way.

What do I have to do?

As a volunteer in this project, you will be invited to take part in one interview lasting up to 60 minutes duration. This interview will be recorded on tape. I am interested in hearing about your experiences of feeding your baby. The interview is an opportunity for you to talk about your experience in your own words. If you find the interview distressing, you will be offered a referral to your General Practitioner (family doctor) or Health Visitor. If you do not wish to take part in the interview, but would be prepared to provide very brief information about yourself and your experiences of breastfeeding, I would be very grateful, as this will also contribute to the study and to understanding women's infant feeding decisions and experiences.

What are the possible benefits of taking part?

The results of this study will be to add knowledge to the health community in obtaining a greater understanding of women's infant feeding decisions and experiences.

Will my taking part in this study be kept confidential?

I would like to stress that all interviews will be treated with utmost confidentiality. Interview audiotapes and interview transcripts will be stored in a locked cupboard and results will be used solely by the investigator for the purposes of the study. Data and interview transcripts will be anonymised. All quotes extracted from the interviews will be anonymous. The tapes will be destroyed after completion of the study. However, if any child protection issues are raised then I have a duty to report this to the appropriate authorities.

What will happen to the results of the research study?

The results of the study will be used for the DHSci and a copy of the executive summary will be available on request.

Who is organising and funding the research?

The study has no external funding. Dr. Sheila Greatrex-White and Professor Diane Fraser will supervise the study.

Who has reviewed the study?

This study has been reviewed by the University Of Lincoln Faculty Of Health, Life and Social Sciences Research Ethics Committee; the Leicestershire, Northamptonshire and Rutland 2 Research Ethics Committee, and is registered with the Lincolnshire Primary Care Trust Research and Development department.

What if there is a problem?

Indemnity is provided for participants through the NHS indemnity scheme, and therefore if you have a complaint concerning this study, or consider that you have been harmed by taking part, please contact Judy Smith, Head of Research for Lincolnshire Teaching Primary Care Trust, Orchard House, Greylees, Sleaford, Lincolnshire, NG34 8PP. Email judy.smith@lpct.nhs.uk, or telephone 01529 416000 x4002

Contact for further information

For further information please contact Rachael Spencer, Senior Lecturer in Nursing at the University of Lincoln on (direct line) (01522) 886384.

Finally, I would like to thank you for taking the time to read this information and for considering taking part in this study.

Rachael Spencer
RGN RHV RNT BSc (Hons) MSc
Senior Lecturer in Nursing
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01522 886384
rspencer@lincoln.ac.uk

APPENDIX 6

Consent Form
Version 2
5th November 2008

An exploration of the breastfeeding experiences of women in one East Midlands city.

- ☐ I confirm that I have read the participant information sheet dated 5th November 2008 (version 2) regarding this study and have had the opportunity to ask questions.

- ☐ I understand that my participation in the study is voluntary.

- ☐ I understand that my participation in the study will be anonymous and confidentiality will be maintained throughout.

- ☐ I understand that I may decline to answer any questions, and have the right to withdraw at any time without giving a reason.

- ☐ I understand that the interview will be audio-taped.

- ☐ I understand that quotes may be taken extracted from my interview and used in the study dissertation and any publications.

- ☐ I have been given adequate time to consider my decision and have been given a copy of the participant information sheet and a copy of this form.

- ☐ I agree to take part in this study.

Name of participant (printed)

Signature of participant

Signature of person taking consent

Date

The return of this form is not necessary if you decline to take part

Contact details for Chief Investigator: Rachael Spencer
Telephone (01522) 886384
Email rspencer@lincoln.ac.uk

APPENDIX 7

Version 1

16th February 2008

University of Nottingham

School of Nursing

Doctor of Health Science

STUDY PROTOCOL

**AN EXPLORATION OF THE BREASTFEEDING EXPERIENCES OF
WOMEN IN ONE EAST MIDLANDS CITY**

Rachael Spencer

Research study title

An exploration of the breastfeeding experiences of women in one East Midlands city.

Research Proposal

The proposed research study aims to develop an understanding of breastfeeding, from the perspective of women who have breastfed. Potential participants will be drawn from a city (Lincoln) in the East Midlands region of the United Kingdom. In order to understand the inherent complexities of successfully promoting and supporting breastfeeding, a woman's breastfeeding experience must be examined within her specific context. A qualitative study utilising an interpretive phenomenological approach is proposed, with in-depth interviews with 30 mothers who have breastfed to explore the experience of breastfeeding and factors influencing breastfeeding decisions. It is intended that the completed research study will contribute to understanding the experience of infant feeding, and factors influencing infant feeding decisions. Such an understanding might influence policy-makers and health care professionals, and help target resources effectively.

Background summary

A body of knowledge has developed promoting breastfeeding globally as the optimum method of infant feeding (Woollett and Marshall, 2000). Breastfeeding has been suggested to represent both a medical gold standard for infant feeding and a moral gold standard for mothering (Knaak, 2005, p197). A review of evidence has demonstrated that on a population basis, exclusive breastfeeding for 6 months is the optimal way of feeding infants (World Health Organisation, 2002). Thereafter infants should receive complementary foods with continued breastfeeding up to 2 years of age or beyond. Despite numerous policy initiatives in the United Kingdom aimed at supporting breastfeeding, breastfeeding rates in the United Kingdom and Ireland are among the lowest in Western Europe and indeed worldwide (Hamlyn et al, 2002). Successive surveys by the Office of National Statistics (ONS) have shown that the incidence and prevalence of breastfeeding in the United Kingdom have increased since 1990. Within England, initiation rates were 78% in 2005 (Bolling et al, 2007), yet there is a noticeable drop during the early postpartum period to 48% at six weeks and 25% at six months (at six months levels of exclusive breastfeeding were negligible). This is in stark contrast to other countries: for example, in New Zealand 68% of women are breastfeeding at 4-6 weeks.

Women approach breastfeeding within a specific social, cultural, political and historical context, yet there is a relative lack of published research into women's perceptions of breastfeeding (Bartlett, 2005). Nine out of ten women surveyed in the latest national infant feeding survey (Bolling et al, 2007) who stopped breastfeeding in the first six weeks reported that they would have liked to have continued for longer. Many studies have been undertaken with the aim of investigating factors associated with weaning in term infants. In a literature review, Dennis (2002) concluded that women who had lower education, were younger, were poor/less well financially situated, or smoked were least likely to initiate breastfeeding and continue

to breastfeed. In addition, low confidence and lack of a supportive network decreased the likelihood of breastfeeding. The reasons that mothers gave for stopping breastfeeding suggest that few mothers gave up because they planned to; particularly those giving up before four months (Bolling et al, 2007). Cessation has been seen as a personal failure (Lawson and Tulloch, 1995) accompanied by intense and sustained feelings of grief (Ryan and Grace, 2001). Hauck and Irurita (2003) found that social expectations strongly influence women's breastfeeding management, and often decrease breastfeeding duration when they were incompatible with their personal expectations. These facts are of great importance to future research on breastfeeding if we are to increase breastfeeding duration in the United Kingdom.

Research Question

The proposed research study aims to develop an understanding of breastfeeding, from the perspective of breastfeeding women in a city (Lincoln) in the East Midlands. In order to understand the inherent complexities of successfully promoting and supporting breastfeeding, a woman's breastfeeding experience must be examined within her specific context.

The research question is therefore:

How is the phenomenon of breastfeeding manifest in the lives of women in one East Midlands city?

Research Objectives

The research objectives include:

- To describe the experience of breastfeeding
- To determine women's perceptions of breastfeeding
- To identify women's planned breastfeeding trajectories

It is anticipated that factors that influence breastfeeding duration and cessation might also be identified.

Design

An in-depth qualitative study of the phenomenon of breastfeeding is proposed.

Theoretical Approach

A qualitative interpretive phenomenological approach is proposed for this study. Qualitative research is an appropriate mode of enquiry when researchers wish to study the understanding and motivation of the research subjects. Furthermore, qualitative research provides systematic evidence for gaining insights into other person's views of the world. The focus of phenomenology generally is to describe accurately the lived experiences of people. Interpretive phenomenology focuses on describing, interpreting and understanding a phenomenon from the ontological

perspective of being-in-the-world, that is, of shared, taken-for-granted contexts and meanings. The findings from interpretive phenomenology are not conceptually structured. Rather, phenomena (what people experience) are uncovered and described in order to develop greater understanding of the phenomenon in question (breastfeeding).

Participants

I am interested in the phenomenon of breastfeeding as it is central to my study to gain the richness and description of breastfeeding women's experience. Non-probability, purposive sampling will therefore be used to consciously select participants who have experienced the phenomenon to be investigated and who have the ability to share the experience in a thoughtful and reflective way (Polit and Hungler, 1999).

In-depth interviews will be conducted with a sample of 30 women who have breastfed to elicit their experience of breastfeeding. Van Manen (1990), Ashworth (1997) and Greatrex-White (2007) postulate that sample numbers are unimportant in a phenomenological study; hence the sample numbers have been chosen to be worthy of the award of doctorate, to contribute to the body of knowledge and to allow for diversity of the phenomenon under study.

Access and recruitment

In order to gain access to potential participants, meetings between the researcher and the Health Visitor manager and Health Visiting teams within the locality have been organised to discuss the proposed study. I propose to ask all Health Visitors in the central city (Lincoln) locality to identify women at their first visit (11-14 days postnatally) who initiated breastfeeding at birth and are currently breastfeeding, and ask them if they might be interested in participating in this study. A participant information sheet outlining the purpose of the study and what it will involve will be provided. If prospective participants are interested in discussing the study further / participating, they will then contact me directly using contact details on the participant information sheet. I intend to collect the data between 3 and 6 months postnatally. To ascertain that nothing untoward has occurred in between these times, I will need to check with the woman's Health Visitor before contacting to arrange data collection.

Participation will be entirely voluntary, and those who decide to take part will be free to withdraw at any time and without giving reason. Written consent will be required prior to taking part in the study, on the understanding that anonymity and confidentiality is assured.

Data collection tool

The chosen data collection method is in-depth interviews. In phenomenology, the data collection method aims to elicit phenomena, that is what the participants experience regarding the phenomenon under study (breastfeeding). The rationale for using in-depth interviewing is to give subjects the opportunity to describe their experiences in their own words, thus ensuring that the data is grounded in women's own experiences. Clarke and Iphofen (2006) suggest that this approach of blending listening

with narratives allows the participant to talk about their experience in their own words with little or no prompting from the interviewer, thereby obtaining a richness of detail and context of the phenomenon being studied. This is important because it is the woman's experience I am after, not some preconceived ideas or conceptual framework.

The interviews will be tape-recorded. This improves accuracy and allows constant reviewing. In addition, I will be able to listen to the participant as opposed to concentrating on note taking. I will transcribe the interviews verbatim as soon as possible after they have been conducted.

Ethical Considerations

Participants will be provided with information on the research study and provided with time for both reflection and further discussion. To ascertain that nothing untoward has occurred in between identification of suitable participants and data collection, I will need to check with the woman's Health Visitor before contacting to arrange data collection. Written consent will be in line with NHS REC guidelines. There will be no inducements to take part in the proposed study. It is important to emphasise that participation in the research study will be voluntary, that there are no right or wrong answers and that the proposed study is exploring infant feeding decisions and experiences. If participants become distressed during the interviews, they will have the opportunity to terminate the interview / their part in the research study. Confidentiality and data protection principles will be strictly observed, for example the identities of participants will be protected by the use of a code that will ensure that all data (tapes and interview transcripts) are anonymised. The code will be allocated once informed consent has been given by the participant. Before data is stored, any identifying data will be destroyed. Audiotapes of the interviews will be stored in a locked cupboard and following completion of the study, cleared of data and destroyed. Documents containing anonymised participant data for the proposed study will be stored in a locked cupboard at the University where it will be available for scrutiny with permission from ethical review bodies for seven years before being destroyed (using a shredder). All data will be viewed solely by the researcher and supervisors, and will not be exchanged electronically.

If I encounter any participant that may be suffering from postnatal depression, referral to the woman's Health Visitor or General Practitioner will be offered.

Proposed project timescale

Month	Action
February 2008	Meetings with Health Visitor locality manager and Health Visiting teams
March 2008	Obtain ethics forms and seek approval
September 2008	Complete literature review Clarify ethical considerations
January 2009	Collect data and analyse
January 2010	Write up methodology
September 2010	Write findings and discussion
September 2011	Complete thesis

Conclusion

This study protocol has attempted to set out a clear and realistic research proposal. The proliferation of social surveys undertaken to establish demographic facts and figures regarding breastfeeding rates demonstrate little regarding the sociocultural aspects of this activity. Society regards breastfeeding in confusing and often conflicting perspectives. A body of knowledge has developed promoting breastfeeding globally as the optimum method of infant feeding (Woollett and Marshall, 2000). Despite numerous policy initiatives in the United Kingdom aimed at supporting breastfeeding, breastfeeding rates in the United Kingdom and Ireland are among the lowest in Western Europe and indeed worldwide (Hamlyn et al, 2002). There is a relative lack of published research into women's experiences of breastfeeding informing professional practice. Breastfeeding is an intense and profoundly human experience that, as a phenomenon, encompasses women's perceptions of themselves as women and mothers, and their relationship with their infant and their closer family. As such this demands an interpretive paradigm of research to explore and describe the lived human experience, to explore the meanings, values and beliefs held by those who experience directly the phenomenon under investigation. This leads into an interpretive approach and qualitative methods that can deepen understanding of the significance of the experience of breastfeeding. This is increasingly recognised as a vital tool in providing effective support by health care professionals in extending breastfeeding duration.

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APPENDIX 8

Faculty of Health, Life & Social Sciences **School of Health & Social Care (Lincoln Centre)**

Minutes of the Ethics Committee Meeting –20th March 2008

1. Present

Sara Owen (Chair)
 Niro Siriwardena
 Fanyi Meng
 Jason Tsai
 Maria Joyce
 John Clayton
 Paul Linsley
 Rachael Spencer
 Andrew Stableford

2. Discussion

The following submitted proposals met the University's Ethical Principles of Conduction Research with Humans or the University's Ethical Principles of conducting Library/Desk/Studio-based projects:

Veronica Byrne
 Louise Bell
 Jason Tsai
 Rachael Spencer

The Ethical Approval form has been signed by the Chair of the Committee and the student/researcher informed of the outcome by letter.

The current Chair, Sara Owen, will be replaced by Paul Linsley from the next meeting.

Future Meetings

Thursday 17th July 2008

All the meetings are from 10.30 – 12.00 in the meeting room, Apartment 7, Court 11, Brayford Campus.

APPENDIX 9**Interview with Jenny**

Interviewer [I]: Let's just take some basics first. Right, you're Jenny, and what's little one called?

Jenny [J]: Jessica.

[I]: And what's her date of birth?

[J]: XX [day] of the XX [month], XX [year]. No, that's me [laughs]

[I]: It's a bit like when it's your birthday at work and do you find you put your birth year down every time you have to write the date?[laughing]

[J]: [Laughing]. Yea, and when it's New Year, in January I'm always the same.

[I]: So how many weeks old is Jessica now?

[J]: She's about 16 weeks.

[I]: 16 weeks. I'll bet that's flown by.

[J]: It has. Don't even remember Christmas and New Year.

[I]: So, she's your first.

[J]: She is yes.

[I]: And what's your husband called?

[J]: Josh.

[I]: Right, so my interview is really to find out about your experiences of breastfeeding. There's no set of specific questions, there's no right or wrong answers, in fact, there's not lots and lots of different questions, it's really just an opportunity for me to listen to your experience of breastfeeding. And I know we talked about me taping the interview, but if I make the odd scribble on my notepad, it's only because you might have said something that I need to remind myself to ask you more about later in the interview. I just really want to hear about your experience breastfeeding, how you've found it, and sometimes if you say things I might ask you to tell me about an incident where that's happened, to tell me more about it [pause]. So, if I was to ask you about your experience of breastfeeding, how would you describe your experience?

[J]: Urm, I go through phases with it. I think when I'm sleeping well and she sleeps better, then I'm positive. But, I think main surprise I had with it, was I thought it would be really easy and everything would be really natural, simple, and she'd know what to do and everything would be fine, but, I, to begin with I thought it would be easy but it wasn't. Well, my plan was to have a home birth, but in the end I ended up going into hospital, not that there were any complications, just because I wanted more pain relief.

[I]: So you were set up for a home birth and started labouring at home?

[J]: Yea. We, I'd done most of it at home and it got to the point where the midwife said if you want anything else and I was being quite sick so I thought right yes, and she said to be honest you're being quite sick so if you want anything for your sickness you're going to need to go in. And I thought right, if I go in, I'm not staying in, because it was not what I really wanted and I didn't want to be kept in [pause], luckily we didn't have any problems. But I think the main problem with that was, because the midwife that had come before Jessica was born I'd had so long with her, the midwife who had been at home, and the one who took over was so busy, she just didn't have the time to support me in the breastfeeding. One or two came in and sort of tried to show me how to breastfeed, but they didn't have the time, I felt like I was always putting on them. So I just thought [pause] I came home and the midwives all said I probably shouldn't have done, I probably should have stayed in. So we came home and it was a bit like oh, I don't really know what I'm doing. So the first day we bottle fed her because I was so tired I can't even remember. After that, obviously the midwives came to the house and for the first two days I said oh yes I'm fine I'm fine, and then on the third full day my midwife who came to do the home delivery came, and she's like why didn't you say and I was like well I didn't like to. And she was like don't be daft, come on and I'll show you how to do it. And she was really good with me, sort of showing me how to latch her on, when she came off, what to do, that sort of side was really good. I think that, in the first few days, because for the first three days we didn't have that. We were playing catch up. She was putting on weight, she was settling but I personally thought, if she woke up after an hour, why are you hungry like? And I think the main problem I had in the first few days was you just couldn't pass it on, you know, you just feed her. But I think as the week went by, she started going into a routine of going at least two hours between feeds, ur, it got a lot easier and ur, at about sort of five six weeks I started going to Sure Start. They do a breastfeeding support group there, but I started going to the baby massage and one of the girls from there, XX with her baby XX, said about it. But I said no I don't want to go there its all a bit too much, earth mothers, and they will have their boobs out, and she said no, they're not like that at all, it's just like a mother and toddler group, and sometimes we don't talk about breastfeeding at all, it's just a nice little group, and it was. There's about five of us that go. So since going to that, you kind of learn things, a lot of them, their babies are older than Jessica, so they've been

through it all already so you sort of sit there listening, thinking, oh right I see. But I think, in the first few weeks, you don't know quite what you're doing. You don't quite have time to read magazines, go online or whatever. I think the main thing those first few, three or four weeks, you're so tired, people coming in and out, in and out, and you just think just go away so I can get my head around this whole breastfeeding thing.

[I]: Right, so if I try and unpick some of that, you started by saying that you expected breastfeeding to be easy, that the baby would know what to do. Is breastfeeding how you imagined it would be?

[J]: No, not at all. I had this image of it being natural and easy, and I would somehow know what to do, and so would the baby. So, no, not at all what I imagined. Not that I'd given it all that much thought before I tried it [laughs]. Probably my own fault really, although I don't think you are prepared for what it really is like, not from what you read and the image that's in leaflets and things. But no, not what I thought, not at all [pause]. I just thought, you know, breastfeeding is a natural thing to do, you know, and I'll know what to do and so will she.

[I]: Right. But that wasn't how you actually found breastfeeding to be? You said you were struggling at first?

[J]: Yes, urm, I did struggle, yes, I did find breastfeeding a struggle, especially those first three days, yes.

[I]: So, if you think back to those first few days at home with the community midwives visiting, why did you not tell them you were struggling with the breastfeeding?

[J]: I think the problem was is that I never had the same midwife, wasn't consistent, I never had the same midwife even through antenatal classes,

my midwife was off sick so I think she had lots of people covering her, because I know, I didn't sort of have a relationship with any of them, so I didn't feel comfortable. Obviously with XX [community midwife], she was the one who came out when I was in labour and so of course then I had eight, either hours with her, chatting with her and just getting to know her. The other midwives, they were all nice, they was all oh how are you getting on and that, and she's putting on weight, all fine all fine, and I was thinking, it's not though, she's always not latching on properly, and, like that so, it was probably my fault as well, my emotions was up in the air, but I didn't want to talk about it. I was quite emotional and I didn't want to cry and them to think I wasn't coping. So I think that was the main thing. I think essentially building up the rapport with your midwife is essential. Like I say, the health visitor was different, I saw her a couple of times but that was much later. I also thought that breastfeeding would come naturally to the baby. I didn't think like she would have to learn it as well as me. I thought if I just swung my boob near her mouth she would know what to do and latch on herself [pause].

[I]: You thought that breastfeeding was an innate skill that both you and Jessica would instinctively know how to do?

[J]: Yea. But you're not really told it isn't though. Midwives obviously they don't have the time, I know that. I know how understaffed they are, completely. But even at the antenatal classes, that kind of thing, nobody really told you about how it was, because all it was was about birth. They have the NCP classes, there looking at that well I probably should have gone there, but then, the time the antenatal class was, my husband works full time, and he's a teacher, getting home at night is like down time for him, not really lots of time to go to NCP classes either.

[I]: Can you talk me through what you remember of your antenatal classes and breastfeeding?

[J]: Urm, I think I just expected them to prepare you a bit more for it really. I suppose you got quite a lot of information all at once, whereas if you got a bit before, then [pause]. Saying that though, the information there when you're pregnant, you're focusing on being pregnant, you kind of focus on your pregnancy, you don't tend to focus on what happens after that, so, I'm not quite sure to be honest. Urm, I think definitely, more information beforehand would be better, just so I felt a bit more prepared. But then [pause].

[I]: And so, you'd not had your home birth you'd had to go into hospital, so I'm presuming that was all an experience that you were hoping to avoid, going in the ambulance in the middle of labour when you'd been hoping to be at home in your own house.

[J]: Yes, because although Josh had wanted me to go into hospital, you know what men are like [laughs], but I'd said I don't want to go in there, people have been doing it at home for hundreds of years, a lot of, you know my mum did her first one, I thought I'm going to be more relaxed at home, I'll cope better at home, and I thought I know myself and I know my own pain threshold, I thought I'll be fine and then, I wasn't expecting being sick at all, and I was constantly being sick with her. And the main problem was being sick, if I hadn't been being sick then I would have stayed at home and coped with the pain. But the fact that I was being sick so much, I personally felt that my contractions didn't give a break between them, I didn't feel like there was a break at all.

[I]: So, when you were in hospital, you didn't feel that she'd fed properly before you went home after six hours.

[J]: No, no I didn't.

[I]: What can you remember about your experience of breastfeeding those first six hours, when you were in the hospital?

[J]: I just remember how busy it seemed.

[I]: So did anybody help you to feed Jessica?

[J]: Yes, one of my friends. I used to work on labour suite on reception, and a couple of people that she was looking after, and I felt, because I knew her as well, that I couldn't ask her.

[I]: Because you knew her personally and as an ex-colleague?

[J]: Yea, because I knew her.

[I]: Why was that?

[J]: I used to work with her before when I was a receptionist there, so I thought it was awkward you know, that sort of thing, but I, it got to that point where she [baby] was crying and my mum said look it's got to the point where she needs feeding Jenny, if you're going to do the breast you're going to have to have help, or do you want me to ask the nurses for a bottle? And Josh said no she really wanted to breastfeed, because I was a bit in and out of it to be honest, they'd given me three injections of drugs to stop me being sick, and I felt so tired, I can't even remember half of it. She [baby] was there crying, so I pressed the buzzer and one of the midwives came in and sort of showed me how to get her on, so here she is she's latched on, and then she went and then she came off and I was like oh, I'm not sure what to do. She kind of physically put her on.

[I]: So, how did that make you feel?

[J]: I, well, who wants to have to show someone your boob, and then have them touch it, grab it and put it in the baby's mouth? It's not, well, it's not the most pleasant of things. And it didn't help really because when she [midwife] went she [baby] came off and I didn't know what to do then.

[I]: So when you asked for help, when you pressed the buzzer to ask for help, the midwife came and helped to put Jessica to your breast?

[J]: Yea, but then she [baby] came off and I didn't know how to get her back on.

[I]: Right, so you didn't feel like, that the midwife had physically put her on for you, if she'd shown you how to hold her and latch her, then

[J]: Yea, if she'd shown me how to hold her and put her on, when she came off I could have had a go myself, but I was like laid on my bed on my side and I just couldn't, sort of laid out in that position, and I just thought if I just put my boob there then she'll just take it, and she was like [pause] you're going to have to put it in my mouth for me, but at the time I didn't realise that, she sort of came off but then she went to sleep anyway, so I thought well I'll leave you to sleep then and then, urm, I went and had a bath and said well I'll go home now. And Josh said well they won't let you go now, and, I think it's my own boisterousness, I don't want to come in here, I don't want to be here, I want to go home, I'm starving, I want, you know better than to argue, so he said, alright then. We had all the bottle stuff at home already because I always said, to be honest from the beginning, I didn't think I would breastfeed for as long as I did, I thought it would keep them all quiet and I'd do it for a week and then bottle feed.

[I]: So you decided to breastfeed because?

[J]: I just thought, to keep everyone quiet, it was what you were supposed to do, I thought oh well I'll do it, but only for a week.

[baby cries, unable to hear words for 25 seconds]

[J]: It wasn't, in my head it was always going to be breastfeed for a week, keep them all quiet then, give her a bottle. That was in the back of my mind, so I had all the bottles in and the formula. But when we came home, obviously I was so tired, Josh said shall we just give her the bottle to keep her quiet and I'll feed her. If I'd known with hind sight that babies can survive, is it 48 hours, without feeding if they don't need feeding, so Josh was feeding her with bottles for the first day, and then obviously it's up to you, whatever you want to do, we'll do it. And I was like, well actually now I really do want to breastfeed, would you mind? and obviously I tried it and then on the third day Xx [community midwife] showed me, and she showed me, because obviously on one boob, like on one side it always felt like she was falling off, she showed me this sort of way, like that, and she went try that sort of thing, and then [baby cries] so then, when she showed me that position and other positions, she said go and do that. And if people are around and stuff, go upstairs and feed her on your side like you have been doing. So urm, so yea she said if you've got visitors and stuff and you've got to go upstairs and they're downstairs, just go and do it. And then we got the hang of it. The more we did it, the better we got. And now it's got to the point where I'm thinking oh no now I've got to stop [baby cries].

[I]: You know when you said you did it in order to keep everybody quiet, who did you mean by everybody?

[J]: I think, urm, I meant the midwives, because urm everywhere you go in the hospital it's breastfeeding, breastfeeding posters and everything. And obviously working on the Unit they'd always be going on about breastfeeding, and I just thought [big sigh] they're going to pressurise me to do it, then I might as well just shut up and do it to shut them up, and then once you start doing it, you do actually feel a lot [pause], there's so much guilt being a parent, in case you don't know [laughs], you do, you think is that the right thing to do, so after a while I planned to put her on

the bottle, but then I got in the swing of it to the point now where I just think, she needs feeding she needs me it's going to happen, whereas at the beginning I was very, I was very embarrassed about it all, you know when relatives come round and that, I'm not one of those people who put them off, who say oh please don't come round, I'm like oh no, come round, come round, whereas with hindsight I think I should have done, I should have put them off coming and telling people that [baby cries].

[I]: You said you were embarrassed in the beginning. What did you find embarrassing?

[J]: The whole exposing my boob, you know, that someone would have to see my boob, yea, that really.

[I]: And was it part of that not wanting to expose your breasts, was that part of why you didn't want to ask people you had worked with to help you with the feeding? Was it that physical thing of you needing help latching Jessica on that stopped you asking?

[J]: Yea, I think it was worse like, they would have helped me, don't get me wrong, but it was that physical aspect of they would have had to see my boob and I just wasn't comfortable. The midwife who delivered me she was one of the night staff so I didn't know her, so that was OK [pause].

[I]: So how do you feel about that now, four months down the line?

[J]: My confidence has definitely gone a long way, it's got to the point now where if she needs feeding there are very few people that I won't feed in front of, her Dad's granddad, but only because I think he would be embarrassed. We sort of go round on a Saturday, do you want a little nap? We sort of go round to his Nanny and Granddad's on a Saturday when there's quite a few of his family members there, and if she's fed then that's

the only time I'd sort of say do you want me to go upstairs to feed her, that's sort of out of the way, but that's only because I think he would be embarrassed. But to be honest I don't think he would be because Nanna has sort of said oh feed her down here if you want to. And in fact, he's old school, he went out to work and XX [mother-in-law] stayed at home, so I thought, well, we won't do it in front of him. Other than that, it doesn't bother me. At first it did, and I wouldn't leave the house if I knew she would need to be breastfed. You know, if we had to go out shopping or do anything, it would be like we had to feed her and then quick, out, get the things and then get back in case she needed feeding.

[I]: So you avoided needing to feed her in public?

[J]: Yes. Definitely the thought of you know going into town during the first four or five weeks, and then it was Christmas and with Josh teaching, he was at home so we didn't need to go out much at all, so he just did everything, so it was something we could avoid. And then my confidence just grew and I thought, well, damn it, we've got to feed you haven't we and they can just look away can't they. Yea.

[I]: So, has she had any more bottles since that first day you were home from hospital?

[J]: She does, she has the night bottle, XX [formula milk brand] just before bed. Just so that because it fills her up more and she sleeps better. I find that because of the bottle she's slept better and I've slept better and I just deal with it a lot better.

[I]: What age was she when you started that? Giving her a bottle at night?

[J]: Urm, two and a half, three months we started giving her it. That was somebody at the breastfeeding support group who said to me, I said she's

not sleeping, she's still barely going two to three hours at night and it's driving me nuts, I just need a night's sleep, and I always wanted her to take the bottle as well, so at first I started expressing in the first few weeks and giving her it in a bottle at night-time so that Josh could feed her at night, it helped a bit but it didn't seem to fill her up because I wanted her to keep having a bit of breast but I wanted a bit of freedom. Then one of the girls at the breastfeeding group said try XX [formula milk brand], it's the closest to breast milk, so it'll make you feel better if you get some sleep, and I gave her a bottle, and that was that really, she's slept better on the bottle [pause] don't you? [pause] I was thinking that, if she [other mother at postnatal group] hadn't said I could give her one bottle I was going to stop and give her all bottles.

[I]: You seem to get some specific practical advice on feeding from a variety of people?

[J]: Yea, from the other mums basically. Like I say, I was very conscious about not going to the breastfeeding support group because I thought, breastfeeding, oh God they're all going to be sat there with their boobs hanging out, I'm not ready for that yet, I was only six weeks into feeding, but XX who went to the Baby Massage said it's not like that, we're not like that at all. Like I say, sometimes we don't even talk about breastfeeding and some of the mums are bottle feeding. And it's just good to just chat to other mums who know what they're doing, and a lot of the advice we've got from there. I'm planning on bottle feeding when I go back to work after Easter, so the plan is to move her onto bottles and I'll probably talk to the girls at the group about it because urm, that XX's mum bottle feeds now and he was breast fed and I think he's about six months, something like that. And I think she sort of did it at the same time, so I'll be asking her how she did it. Because she said to me, oh when you do it, don't do what I did because I just totally stopped and I had such problems and you don't want that. Don't want that. But the midwife there knows and I told the health visitor, but I think I'll talk to the other mums.

[I]: You wanted Jessica to have a bottle because you knew you were going back to work?

[J]: Yea, and, yea, I wanted, my mum's very hands on as well and my mum's always like wanted to feed her. My mum's always totally like supported my breastfeeding her, she's sort of like won't it be nice for me to feed her a bottle and that, so I always wanted her to be bottle fed and also, my friend XX who works at XX, her boy XX, he was breastfed but she never gave him a bottle and then it got to the point where he was five months and [baby cries] I didn't want to get to that, I didn't want to get to the point where I'm at work and oh God she won't take a bottle what are we going to do because I knew I didn't have the luxury of being able to stay at home with her for maybe as long as XX [friend] stayed at home in the end, not that my maternity leave is for much longer but I knew I'd be getting back to work and she'd need to be taking a bottle. So that's what I planned and also, just that one bottle a day Josh can give her and I can also go out, if I, not that I want, not that we have, we've been out once I think [laughs]. But I also thought, if I ever want to leave her with anyone, just, if I needed to, then I would be able to.

[I]: You said you started off expressing your milk and giving her that in a bottle?

[J]: Yea, I started doing it yea. Urm, because I wanted her to keep having a bit of breast but I wanted a bit of freedom, then I found that it took me so long to get enough and then what was enough, that was my main question? You know, about 5 ounces, five or six ounces, but that took me two or three goes to get what I would consider was a bottle, and it felt like I was either feeding her, expressing for her, cleaning the expressing gear so I could do it again after I'd fed her again, it was like, it's time enough feeding you. That's why I've moved over to the XX [formula milk brand]. It's the closest to breast milk. And you like it, a little treat.

[I]: So how do you feel about breastfeeding now? You thought it would be natural, instinctive for her, she'd know what she was doing, and you had this perception of breastfeeding moms as 'earth mothers'?

[J]: I think now it's [pause] it's, I don't know, I don't think I'd have bonded any more with her if I hadn't breast fed because I personally would have probably had more time to actually spend kissing her and hugging her [laughs]. Instead of mucking around trying to get her to feed [laughs]. But then saying that, in time because you know when you're breastfeeding you've got to sit down and you haven't got the choice of running off and doing something else, not feeding, but it tends to be a lot quicker when you're bottle feeding her than you do have to sit down for twenty minutes half an hour to feed her. And I like it, don't we, we quite like it. And she gets on a lot better with it [pause]. She's just started scratching at my chest when she's feeding. I've got all scratch marks on me.

[I]: So, you're aiming to go back to work very soon, what are your plans for feeding her?

[J]: The plan is that we're going on holiday for a couple of weeks and I'm going to breastfeed her until then, and when we get back I'm going to slowly wean her on bottles.

[I]: And how do you feel about that?

[J]: I thought I'd be really relieved, I thought oh well, it will be great, I'd have all this freedom, but the more I think of it, it's going to be more hassle buying the bottles, making the bottles up and it's generally because I'm not going to be there in the day. Mixed emotions – one day I think oh brilliant, it's going to be great, she'll be on the bottle I can pass her to anyone and anyone can feed her and I can have a break, and other days I think no, that's my job, I don't want to pass her on. I'm in two minds, two minds aren't I.

[I]: So in some ways you sound like you are actually appreciating the fact that it's a unique situation, breastfeeding, for you and for Jessica?

[J]: Yea. It's took time, it really has. At the beginning I thought it was going to be so simple and it was going to be harder bottle feeding, I'd be constantly worrying is it sterilised enough, is it made up properly, have I got enough to last us the day, you're not supposed to make them up before all that sort of hassle. But I think it's just going to be something different. Different's not all bad is it. It's just different.

[I]: You said earlier that your husband wanted to feed her. How's he been with regards to breastfeeding?

[J]: I think he's just very practical same as me, so she's got to go to nursery three days a week, I sort of said to him the other night, I was going through one of my I don't know if I want to put her on bottles, actually I enjoy feeding her. It's simple and it means we can just go out, and just do what we want, you know we don't have to plan or think about it, just take her and a changing bag sort of thing. I said when I put her on bottles I think that will really spoil it. And he was like yeah. I was like yea I think I might. And he was like, oh I didn't think you'd be like that, I thought you'd be ready to give it up. Remember when you did the first few weeks of it and you were going to stop then [pause]. I don't know, I change my mind from one minute to the next. But I think, I think he's looking forward to it as well, he'll be able to feed her a lot more and be a lot more active [pause] well obviously he's gotta be, it'll be a change for her and I think it'll be strange for her if she smells my milk on me, thinking why are you giving me this.

[I]: And you said in the early days, you avoided going out in public to feed her.

[J]: Definitely.

[I]: Can you tell me more about that?

[J]: Now it doesn't bother me at all. And [pause] yea, I'll breastfeed her anywhere.

[I]: Can you tell me more about that. Think of a typical day when you have to go out somewhere.

[J]: That's easy. I spend a lot of my time out sort of going round the family in the day time, round friend's houses, going round to my mum's or Josh's Dad's and, and I thought at first I'd be really embarrassed feeding round his, it's not the same as your own mum, she's seen my boobs although I thought it would be a bit of a surprise for her, but, I thought it would be a bit weird for Josh's Dad and Josh's got two step brothers that are like 16 and, no 18 and 21 now, that's a bit of a weird age as well, but I just sort of said to them the first time look I'm going to be breastfeeding, is that alright, I won't just do it, I don't want to make anyone feel uncomfortable in their own house, and XX and XX were absolutely fine about it. Oh no, no, no, no don't worry, you just, we know it's just a natural thing. And once or twice, XX who's the older one, he's 21, he's sort of like come in and he always come up and said hello and he's done that a few times and he doesn't realise that I was feeding her, and went I'm really sorry, I'm really sorry, and I'm like oh no it's fine, it's fine. Oh well I'll come back for a cuddle later then. And it's been fine, but I think, it's just at certain ages, I think it's just pre warning them, but out and about in town, it doesn't bother me. If we're sat in a café or coffee shop, or if I'm in town I tend to go to Mothercare quite a bit because their little nursing room is nice. We also still plan things where we think right, we can either do this, this and this, and I'll feed you now, or we go as quick as we can. There are also situations where we have to feed her, it doesn't bother me if we have to [baby cries].

[I]: Can you tell me a bit more about how your experience of breastfeeding has been different to your expectations?

[J]: [baby crying] Calm down, calm down, sorry.

[I]: It's alright [pause]. You said that you felt the preparation you had antenatally was focussed on the birth?

[J]: I think they just give, yea, a little bit inaccurate maybe. I think they just want to polish it up a bit, I don't think they want to mislead you, but I'm not sure if they've got, obviously the best thing for them, breast milk is the best thing for them, but I think that by trying to sell it in a certain way it makes you feel inadequate because your baby's not doing that, that's what my main problem was, not feeding for twenty minutes, oh my God I'm not feeding her for enough, because that's what she should have, she should be feeding for twenty minutes or thirty minutes. The fact that's she's full and that's she's settled, as a new mum you don't think that, on day one [pause].

[I]: So how did you find out that the amount and how often you were feeding her was alright?

[J]: Urm, I think I just settled into myself. I just thought she's fine. I just need to stop stressing about this time thing. Because like ten minutes now and then that's what she's going to have, and then later perhaps thirty minutes, or thirty five minutes, she'll have it. Do you know what I mean? Then we settled into more of a routine when in certain times of the day she'll only have twelve minutes at the most and at others she'll have at least half an hour. You just have to get on with what she wants. I think the health visitor, not the health visitor, the community nursery nurse, I've phoned her a few times and I've sort of said she's not feeding for twenty minutes and she's, she's been really good. She's come out a few times and weighed her and stuff. Look, she's putting on weight, she's settled between feeds. Stop stressing about this time thing. She said it's, it's what recommended but it's not the bees all and ends all of it all. So yea, between that and I think me just relaxing into it, I think that was it.

[I]: But you don't think the picture painted in the information you received during pregnancy and in the leaflets you were given was accurate in terms of your experience of breastfeeding?

[J]: No, not as much. I think, although I don't know, maybe I just took it all too literally and, you read that the baby should do this and this and you think that's it then, and in certain respects that's what the baby should do. That's it and that's it every time. Whereas when you think about it, it's like sometimes I just want an apple and then sometimes I want a big sandwich, and some crisps, and then an apple, so you can be, well it's probably the same for babies, yet sometimes in the literature that's not how it comes across. Like I say, one magazine was very good about breastfeeding and urm, I probably didn't read enough when I needed to, but how do you find the time to do that in those first few days [pause].

[I]: And you said it was one of the other mums in the breastfeeding group

[J]: Yea.

[I]: who talked to you.

[J]: Yea, I was talking to the, yea, one of the mums at the breastfeeding group, look she's not sleeping, looking back it wasn't that bad [laughs] but at the time when you're in it [laughs] and getting like two hours sleep because between that I'm settling her, and I didn't know, you know you hear people like my sister, well my babies ur bottle fed, they all slept through sort of thing, maybe that's what she needs, maybe she needs more, I don't think I'll give up on it she said, because my boy was bottle fed by that point she said and I don't get it any easier or any quicker, if anything she said I get more hassle because you know like I have to make the bottles up. Persevere she said, but just give her one bottle just before like sleep time and as she'd been bottle fed before it's meant to be like breastfeeding but I got on really well with it, and you'll be better well

rested and you'll be able to cope better so she'll probably sleep even better. Like I say with one bottle and she seems to go six hours after her last feed and that's enough

[I]: That's enough to give you a boost to carry on

[J]: Yea, enough and then she wakes up at about half past four and then I put her down to sleep for a couple of hours.

[I]: But you think potentially

[J]: Yea, without a doubt, I was at that point where I thought I need to get some sleep because if she's on bottles then Josh can feed her a bit in the night, and then we can swap over. Obviously because he drives to Grimsby for his work, he can't do that every night but at weekends he always offers to give her a bottle and I get to the point where I say if you can give her a bottle at night and I can like go to bed at nine o'clock and then I can do the half past four feed and feel refreshed.

[I]: So it was because you were so tired that you introduced a bottle at night time?

[J]: I think so, yeah. I know it was only because I was so tired, and I kinda prepared for it in a way, but not really [laughs]. It was, you know you're going to be challenged, you know the baby's going to cry, but then when it hits you and you've kinda spent nine months being pregnant, so it was definitely one of the learning sort of things where a bottle at night, but most of the time it's just knowing that she can do it, that she can bottle feed [pause], but now I either go to bed early or I don't and like I've got the night off [laughs].

[I]: But in essence you feel if the lady at the breastfeeding group hadn't suggested a bottle, you may have potentially stopped breastfeeding all together, did I get that right?

[J]: Yea, I was thinking that, if she hadn't said I could give her one bottle I was going to stop and give her all bottles, because I knew she was going to have to have all bottles anyway when I go back to work, and I didn't know you could give one bottle and it would work, yea.

[I]: Do you still go to the breastfeeding group?

[J]: Yea, it's a nice little group and the babies are like at all different ages as well, so you've got all the mums and it's, yea, out of all the, all the groups like I've got a social life [laughs] we just go to a couple of mums and babies, but I think that's one of the better ones in terms of support, and like I say it's not all about breastfeeding but if ever I have a question it's like with her going onto all these bottles I'm going to ask them for their advice on how they done it. You know I'm going back to work soon and I'm going to give it a couple of weeks to get her on them [pause].

[I]: And is that the sort of question you would ask anyone else?

[J]: Urm, the health visitor, the one up at the surgery I haven't sort of seen much, but the ones up at Sure Start, there's about three or four different sorts, they're all really lovely there and to be fair I probably know them better. One of the Community Nursery Nurses, I could ask her. I think it's building up the rapport, like strangers coming in to your house, and the last thing you want is some stranger coming into your house and you feeling like you're doing stuff wrong. And they never do, don't get me wrong, they never say oh you're doing it all wrong and your house is a mess and everything, but you can feel that because you know the baby's fine and nobody's made you feel like that, but I think that's more of a personal thing [pause].

[I]: So you tend to ask the other mums because you have that rapport with them?

[J]: Yea, I think that yea. Definitely [pause]. This has been a total turn around for me. It's shocked my family as well because I said I was going to breastfeed her when I was pregnant. I don't know why I, like I say I'm not the earth mother type, I'm not saying that I probably am because I'm breastfeeding and she's used, she has reusable nappies, so I probably am, but [pause] I know I have changed. My mum said she never thought I would have a total turn around, because I was quite career orientated, at [work], whereas now I think oh if you don't want me coming back then another six, eight weeks off, fine. And then, sort of thing, my mum said she never thought I'd stick to breastfeeding.

[I]: So why did your mum and your sister think bottle feeding was more for you?

[J]: I don't know. My sister's got three kids and all three of hers weren't breastfed, I know the first, the first daughter was born by Caesarean and went to the Special Care unit and she didn't get on with the breast pumps and stuff, and so that put her off and I think that really put her off even more and I think my mum thought that even though I told her I wasn't going back to work straight away, but I think my mum always thought that after a bit I'd go onto the bottle because, although she knew I wanted to be a mum [pause] I just think she thought I wasn't going to be like that. But now I go round to my mum's most days and I breastfeed and she says like you've changed and I never thought that you would like come round and breastfeed, and I was like, no I could never imagine that when I was pregnant either, but [pause] even my personality, mum just thought [pause].

[I]: Can you tell me a bit more [pause] about why you think your mum [pause] and you I suppose didn't think you would breastfeed, well, not for as long as you are?

[J]: Urm [pause] I think there's a connection between being a good mother and breastfeeding, and I think although I did want to breastfeed, I only really wanted to do it so they wouldn't be on my back about it, and then I'd go onto the bottles, because as I say I am going back to work soon and she's got to be on the bottles then, and you might not think it but I was sort of career minded [laughs] and my mum [pause] well I think it was always sort of that I'd go back to work and she'd be on the bottles and because my mum's going to have her a bit when I'm at work [pause].

[I]: Do you think that breastfeeding is, urm, linked with being a good mother?

[J]: There is a connection I think, like I say I think more than anything it's the fact you stop doing all your housework, you think about what needs doing and you think I've got to sit here and just feed her. So it is definitely the time they need, you haven't got a choice, you haven't got [pause]. Some mums say they carry on doing things while they're breastfeeding. That's not something I can do. I struggle keeping her on, making sure she's getting enough without getting too much wind. I take time to feed, I stop, I sit down [pause]. I have days when I think, yea, I can go out, start drinking, yea I think that might also have been why my mum thought I wouldn't breastfeed [laughs]. Not that I'm a drinker obviously, but I did like a glass of wine at the end of the night, and I know you can when you're breastfeeding but it's very rare that I do. And I think my mum thought I could go out at night and get a babysitter, but I'm too tired and it's too much effort to go out. My mum always thought yea she's on the bottle she'll be able to go out and carry on with her lifestyle, yea.

[I]: Do you know if your mum breastfed you?

[J]: You know, I don't know [pause] but yea, she must have done because she always blames me for losing her teeth, she said, I don't know, she said it was at that point where bottle feeding was not that good and she got that calcium deficiency, I took all her calcium in her milk, that's what

she said anyway. And my sister, well she's obviously quite a young mum and so mum can help her with all the bottles and that. And I think my mum thought because she helped my sister like that and with feeding her children that she could do the same with Jessica. Oh she's pulling my hair out now [laughs]. She doesn't like me talking to you does she [laughing].

[I]: Just in case you're talking about her [laughs]

[J]: Misses nothing [pause]. When she was so little I was like watch her cry so I have to breastfeed her. At least now she's responding and smiling so at least I get something back.

[I]: You get something back from her?

[J]: Yea, yea. And also now she's in her own bedroom, like the cradle we had in our bedroom was quite small, she was flinging her arm out and it was waking her up. So she's in her own room, in the cot bed. For the first few nights obviously she'd been bottle fed and I had a chair in there, but she was used to coming in the bed lying down to feed, so in that case I don't think I'll bother waking up, I'll stay asleep until the morning thank you very much [laughs]. One of these days, you'll sleep through.

[I]: Has breastfeeding had any effects on you?

[J]: Weight, [laughs] 'cos I eat like a horse. That's one of my worries when I stop [laughs]. Then other days I think who cares. I was watching, I don't know if you saw it last night, that Louise Rednapp super skinny pregnancies?

[I]: Oh no

[J]: She was talking about losing the weight afterwards and I thought some of the women spend six hours a day being away from their baby. Americans. One of them was five months, just had a baby five months ago, was going under major surgery to have a tummy tuck, a breast lift and her, her bum done. I was like [pause]. They was like saying that because of the tummy tuck there was more chance of her getting like blood clots and dying and I thought you've got a five month old baby, why would you put yourself through that, why not breastfeed [laughs]. It seems to work for me [laughs]. Stupid Americans what do you say [laughs]. Like I say, at the beginning I was probably nervous about things like that, you know, feeding her in public, but I think it's confidence at feeding her properly, 'cos if I wasn't feeding her properly, because I thought if people did look, and I thought oh if I'm out and about people might think that. But I don't know why because if I've ever fed her out in public, people tend to not bother, to be honest, and, there was one woman who went to baby massage and she had one of them wraps to cover her and the baby and I always thought to myself it made us look at her more, if anything I stare more at you because I think to myself, what's she doing, where's the baby gone, that sort of thing, and I thought, yea, because my husband said shall I get you one of them because it might make you feel better, and I was like if anything it would draw attention to me, whereas if I'm feeding her like this most people will just think I'm hugging her or holding her, or rocking her to sleep, and nobody really notices if you've got quite a good top on. If you've got to get them out, get them out [laughs].

[I]: And how is Josh about that, you feeding her in public?

[J]: I thought he'd be really funny because he is reserved, very reserved in his mannerisms. He wouldn't put himself out there sort of thing, And I thought oh he's totally different; he's totally changed since having her. He'll come up and I never thought he'd come up when I was feeding her as well. He's like oh you're feeding, you'd better do it properly or your mum will be cross. I never thought he'd do that. He brings her to me and stuff. When he's getting up for work he's like shall I get her and I'm like go on then and I didn't think he would. If anybody ever said anything he'd be the

first, he'd be the first person to, I think he'd be like have you ever heard Jessica cry, well if I take her off you can listen to her crying. He's absolutely fine. I think to begin with he was like any new Dad, it was easier to say she was hungry, then I could do it, whereas now, now he's definitely going to be a lot better, he'd definitely be the first to say to someone keep walking keep walking, none of your business. Urm, and if I'm like feeding her and that he'll wind her, and if she's going on the bottle then he's going to have to be more active with her. To begin with when I said oh we'll put her on the bottle he was like do you want to feed her, because otherwise she'd be mardy, like why are you giving it me out a bottle? He was like I'll do it every night, but now it's well I can't do it on a Wednesday because it's clubs, and I'm really tired and it's started to creep that way. I'm like well you wanted to feed her, shall we just leave her to cry because it's your turn to do it [pause].

[I]: So, if I asked you to talk me through a specific example of a day, your experience of breastfeeding, just one day, or one incident, how would you describe it?

[J]: That's really hard to describe, it's changed over the four months. Like I say, I struggled in the first three days, a lot. I wasn't sure how to get her on my boob, she kept falling off, and I couldn't get her on because I was on my side a lot, and I didn't know if she was full or not, I didn't know how long she was to go between feeds. I was embarrassed, and I was trying to pretend I was coping because I'm stubborn and I wanted to go home and then I went home, but I didn't want to let them [health care professionals] know I was struggling so I pretended I knew what we were doing. But we didn't do we, hey. And we had all the bottle stuff at home anyway, because I didn't think I was going to breastfeed for long anyway.

[I]: OK. It sounds like your initial experiences of breastfeeding were nothing like you had anticipated, and you had prepared yourself to breastfeed just for a short while after she was born and then bottle feed, but have then ended up still breastfeeding, with the occasional bottle of formula mainly at nighttimes.

[J]: I've been reviewing it as well, you know sitting there at half past four this morning, well actually it was half past two, thank you [laughs], yea I've been reviewing you know because of you coming [pause]. I might have stayed more in the hospital than having her straight out, then I probably would have gone down to Nettleham Ward and actually settled her down there a bit more, and then probably would have got on better instead of playing catch up [pause]. But I was stubborn, stupid or stubborn [laughs]. I don't blame the midwives at all. Like I say when we tried a few days later she [baby] always seemed to prefer this side, and this one she only sort of [pause]. Like I say the pictures in the magazines sort of show you how to do it, but you need someone to actually sit with you and go through it with you. This is how you put her on. When she falls off, this is how you put her back on. That's what I needed. Someone to take time to go through it with you. Even just to talk through things like how often they feed, how to know if it's a feed they need or something else. But yea, I had no idea what I was doing and neither did she [baby] so we needed all that.

[I]: Does she still have a preference for one side?

[J]: No, it was only the way I was holding her. I was saying to Josh before I'd spoke to the midwife. She won't feed on this side, goes on and comes off, and she was like I'm not judging you or nothing, I'm only saying, but when you hold her on that side, you hold her different. You do, there's like a big gap where her head should be and it falls down, whereas on this side you tend to hold her tighter. And I was like, do I? And when I saw the midwife, urm, oh come on let me show you how to do it, come on. It didn't feel weird at all.

[I]: Did she show you in a different way to how the midwives in the hospital first showed you to latch Jessica on?

[J]: Yea, because she showed me all different ways, whereas on labour ward I was laying down and they put her on. I didn't do anything.

[I]: They put her on for you?

[J]: Yea, it was like, it wasn't my midwife, I was laying down and they put her on. You know, it wasn't like this is what you do. Whereas XX [community midwife] was like, come on, this is how you do it.

[I]: So she manoeuvred your hands to show you?

[J]: Yea, she was much more, you've got to hold her like this

[I]: I see.

[J]: Tuck her bum under.

[I]: Yes.

[J]: And if you're laying down, do it like this, and you want to hold her like this, tuck her bum in like this and this across you, whereas things like that, I don't know. I was just holding her like you think you're holding her. Not like this. Why isn't she getting it, why isn't she doing this? And nobody actually mentioned to bring the baby to the boob. It never occurred to me. There was me wriggling my boob around thinking just take it just take it [laughs]. Nobody sort of like, because she'd latched on at one point I ended up sat here. But XX [community midwife] said you don't have to chase them with the boob you know. You know, boobs hang where they are, and then you make her come to you. I was like, ah I see [laughs]. You kinda think it's going to come naturally, but it doesn't, you don't actually get it straight away. You need help [pause].

[I]: And you also said earlier that she didn't know what to do, it's a two-way learning process.

[J]: Yea, definitely. Cos I thought she'd just get it straight away. I thought, my daughter, she'll come out and know what to do straight away. Surely she'll know how to do it. But then you think back, she needed help and so did I [pause].

[I]: Yes [pause]. Is there anything else you think I ought to know about your breastfeeding experience with Jessica? Perhaps something that you haven't had the opportunity to say but you feel is important?

[J]: No, I don't think so, I think I've said it all. Like I say, I did revise last night what I wanted to say to you, so I think you've got it all [laughs].

[I]: Well, in that case, I'd just like to say thank you. You've been so generous in your time, and so honest. I'll switch this off now.

[Data ends].

Interpretive summary – Jenny

Baby 16 weeks old.

First baby (female).

BF plus occasional (daily) bottles of formula milk (since 10-12 weeks of age).

30 years old. Married. Husband is a teacher, works one hour commute from their home.

Maternal and paternal grandparents live locally.

House on socio-economically deprived estate, with a range of amenities including primary and secondary schools, health and general practice centres, shops, churches and a Sure Start centre.

Works as a Human Resources Administrator – will be returning to work but has not yet.

Seemed open and relaxed throughout interview.

She had been thinking about her experiences of infant feeding prior to the interview.

<p>Expectation that breastfeeding was a natural process.</p> <p>Not prepared adequately for breastfeeding. Antenatally, focussed on being pregnant, antenatal education classes centred around birth experiences.</p> <p>Breastfeeding literature not realistic.</p> <p>Found breastfeeding to be tiring and she was exhausted. Regrets not discouraging the visitors in the initial postnatal period.</p> <p>Neither mother nor baby knew how to breastfeed. She expected it to come naturally and easily to her, and that her baby would be born and instinctively know how to fix at the breast and feed.</p>	Idealistic expectations	Reality Shock
<p>Needs feeding = needs me. Responsibility lies ultimately with mother. Felt onus of responsibility for feeding in the first few days that she was not able to pass onto anyone else.</p> <p>Wants own life, a degree of separation and freedom from breastfeeding / baby.</p> <p>Was not expecting the amount of time it takes to sit and breastfeed.</p>	Onus of responsibility	
<p>Intention antenatally to breastfeed for the first week after the baby's birth. No intention to breastfeed longer than that.</p> <p>Breastfeeding synonymous with the good mother image.</p> <p>Described her decision to breastfeed for that first week to 'keep them all quiet'.</p> <p>Pretended to be coping for the first few days when receiving care from different midwives with whom she did not develop a rapport. Eventually admitted to the midwife who she had got to know during intrapartum care at home that she was struggling with breastfeeding.</p>	Playing the game	Illusions of

<p>Antenatal preparation for formula feeding after an initial postnatal week of breastfeeding. Heeded advice on infant feeding from other mothers at postnatal breastfeeding group. Started at 2.5 months to introduce expressed breast milk via bottle, given by the baby's father, but this didn't result in a longer sleep pattern for the baby. Also, time and effort to express her breast milk was too onerous. Introduced formula milk feed at night in the belief that this would enable the baby to get more sleep. Finds that can then cope with the rest of the day breastfeeding at each feed if the baby has slept at night. Would have completely stopped breastfeeding if she had not introduced one bottle of formula and found this works for her, contrary to the advice of health care professionals. Emphasises that the brand of formula milk she has chosen is the closest to breast milk. Describes it as the baby's "treat", and that this has not adversely affected bonding between mother and baby.</p> <p>Prefers to ask other mothers for advice on mixed feeding / stopping rather than midwives or health visitors.</p> <p>Also now confident that the baby will be content and settled with formula milk feeds when she returns to work.</p>	<p>Breaking the rules</p>	<p>compliance</p>
<p>Dislike of hands on assistance with breastfeeding that she described receiving on the postnatal ward. Described a lack of help in hospital with breastfeeding. She knew one of the maternity staff from having worked herself on the maternity unit previously – she felt uncomfortable asking that person for help. Described one midwife physically positioning and latching the baby at the breast when she eventually buzzed for help at maternal grandmother and partner's</p>		

<p>insistence. She wanted to be shown how to position and latch the baby so she could then do it for herself.</p> <p>Midwives were too busy to help. No rapport with the midwives. Described there being one or two who came in to show her how to breastfeed, but they were too busy to stay. She felt that she was putting on them, so came home six hours after the baby's birth. States in interview she probably came home too soon, as in she didn't know what she was doing with breastfeeding on discharge.</p>	Conflicts and contradictions	Tensions
<p>Visitors meant that Jenny had to go upstairs to try and breast feed. She regrets not putting off the visitors as she was not comfortable feeding in public, but did not want to deter visitors in the early postnatal period. Public breastfeeding – discretion when needing to feed in front of grandfather – offers to feed upstairs. When baby first born, avoided breastfeeding in public by either staying at home, or timing outings around feeds. This lasted for about 6-8 weeks. Self confidence needed to breastfeed in public. Later in interview acknowledges that she has had no adverse comments in public, that nobody actually notices. Public and private spheres to breastfeed.</p>	Cultural constructs	